AGING VETERANS' HEALTH CARE ISSUES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS

AND THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

APRIL 23, 1985

Printed for the use of the Committee on Veterans' Affairs and the Select Committee on Aging

VETERANS' AFFAIRS COMMITTEE
SERIAL NO. 99-13

SELECT COMMITTEE ON AGING
SERIAL NO. 99-501

U.S. GOVERNMENT PRINTING OFFICE
49-445 O WASHINGTON : 1985

H141-41
H761-29

COMMITTEE ON VETERANS' AFFAIRS

G.V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
BOB EDGAR, Pennsylvania
SAM B. HALL, Jr., Texas
DOUGLAS APPLEGATE, Ohio
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
WAYNE DOWDY, Mississippi
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, Jr., West Virginia
J. ROY ROWLAND, Georgia
JOHN BRYANT, Texas
JAMES J. FLORIO, New Jersey
KENNETH J. GRAY, Illinois
PAUL E. KANJORSKI, Pennsylvania
TOMMY F. ROBINSON, Arkansas

JOHN PAUL HAMMERSCHMIDT, Arkansas
CHALMERS P. WYLIE, Ohio
ELWOOD HILLIS, Indiana
GERALD B.H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
DAN BURTON, Indiana
DON SUNDQUIST, Tennessee
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut
GUY V. MOLINARI, New York
THOMAS J. RIDGE, Pennsylvania
WILLIAM M. HENDON, North Carolina
JOHN G. ROWLAND, Connecticut

Mack Fleming, *Chief Counsel and Staff Director*

Subcommittee on Hospitals and Health Care

BOB EDGAR, Pennsylvania, *Chairman*

DAN MICA, Florida
WAYNE DOWDY, Mississippi
LANE EVANS, Illinois
MARCY KAPTUR, Ohio
ALAN B. MOLLOHAN, West Virginia
TIMOTHY J. PENNY, Minnesota
HARLEY O. STAGGERS, Jr., West Virginia
J. ROY ROWLAND, Georgia
JOHN BRYANT, Texas
JAMES J. FLORIO, New Jersey
PAUL E. KANJORSKI, Pennsylvania
TOMMY F. ROBINSON, Arkansas
RICHARD C. SHELBY, Alabama
THOMAS A. DASCHLE, South Dakota

JOHN PAUL HAMMERSCHMIDT, Arkansas
ELWOOD HILLIS, Indiana
GERALD B.H. SOLOMON, New York
BOB McEWEN, Ohio
CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
NANCY LEE JOHNSON, Connecticut
GUY V. MOLINARI, New York
THOMAS J. RIDGE, Pennsylvania
WILLIAM M. HENDON, North Carolina
JOHN G. ROWLAND, Connecticut

Select Committee on Aging

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, Jr., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
FREDERICK C. BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
ROBERT E. WISE, Jr., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
TOMMY F. ROBINSON, Arkansas
RICHARD H. STALLINGS, Idaho

MATTHEW J. RINALDO, New Jersey
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona
BILL SCHUETTE, Michigan

CONTENTS

APRIL 23, 1985

Page
Aging Veterans' Health Care Issues 1

OPENING STATEMENTS

Chairman Bob Edgar 1
  Prepared statement of Chairman Edgar 75
Chairman Edward R. Roybal 3
Hon. John Paul Hammerschmidt 4
Hon. Olympia J. Snowe 5
Hon. Tommy Robinson 7
Hon. George W. Gekas 7
Hon. Thomas J. Manton 9
Hon. Bill Schuette 10
Hon. Mario Biaggi 21

WITNESSES

Aviles, Albert L., national service officer, Disabled American Veterans, Los Angeles, CA 11
  Prepared statement of Mr. Aviles 91
Custis, Dr. Donald L., director of medical services, Paralyzed Veterans of America, and former Chief Medical Director, Veterans' Administration 50
  Prepared statement of Dr. Custis 118
Dallery, Carleton, Director, Department of Social Services, Bryn Maur, PA 28
  Prepared statement of Dr. Dallery 99
Ditzler, Dr. John, Chief Medical Director, Veterans' Administration; accompanied by Dr. John Mather, Assistant Chief Medical Director for Geriatrics and Extended Care; Marjorie Quandt, Assistant Chief Medical Director for Administration; James Gregg, Deputy Director, Program Analysis and Development; and Audley Henricks, office of the general counsel 60
  Prepared statement of Dr. Ditzler 121
Hunter, Jon, director, Area Agency on Aging, Fairmont, WV, and treasurer, National Association of Area Agencies on Aging, on behalf of the Leadership Council of Aging Organizations 31
  Prepared statement of Mr. Hunter 101
Jacobsen, Barry, on behalf of the American Health Care Association 32
  Prepared statement of Mr. Jacobsen 104
McLeod, Charles M., national service officer, Disabled American Veterans, St. Petersburg, FL 13
  Prepared statement of Mr. McLeod 93
O'Neill, Raymond G., director, veterans service, State of Michigan, Veterans of Foreign Wars 15
  Prepared statement of Mr. O'Neill 95
Rowe, Dr. John W., director, Division on Aging, Harvard Medical School, deputy director, Division of Health Policy Research and Education, Harvard University, and director, VA Geriatric Research Education Clinical Center 42
  Prepared statement of Dr. Rowe 113

MATERIAL SUBMITTED FOR THE RECORD

Letters:

Page

- From Chairman Edgar and Chairman Roybal to Department of Health and Human Resources Secretary Margaret Heckler, re basis for administration's estimate of the effects of proposals on health care eligibility.. 77
- From Department of Health and Human Services to Chairman Edward Roybal, declining subcommittee request that the Department provide a witness to give testimony at the joint hearing on April 23, 1985, regarding health policies for older veterans 79
- From Administrator Walters to Chairman Edgar and Chairman Roybal re VA's legislative proposal to revise medical eligibility, and the impact of such a proposal 80
- From Chairman Roybal to OMB Director David A. Stockman, re proposed means test for veterans 35

Memo:

- From Steve Bell, staff director, Senate Budget Committee, to Republican Senators and Legislative Directors, re Senate-White House Deficit Reduction Agreement 125

Reports:

- Potential for Reliance on Community Hospital and Nursing Home Care to Meet Veterans' Health Care Needs 88

Statements:

- Fisk, Carol Fraser, Acting Commissioner, Administration on Aging 125
- Davis, Carolyne K., administrator, Health Care Financing Administration 126
- Pavlik, John, national commander, Veterans of World War I of the U.S.A., Inc 128

Written committee questions and their response:

- Chairman Roybal to Disabled American Veterans 129
- Chairman Roybal to Veterans of Foreign Wars 131
- Chairman Roybal to Dr. Dallery 131
- Chairman Roybal to National Association of Area Agencies on Aging 132
- Chairman Roybal to American Health Care Association 133
- Chairman Roybal to Dr. Donald L. Custis 135
- Chairman Edgar to Dr. John W. Rowe 136
- Chairman Edgar and Chairman Roybal to Veterans' Administration 137
- Chairman Roybal to Department of Health and Human Services 141
- Chairman Roybal to Agency on Aging 144
- Hon. John Paul Hammerschmidt to Veterans' Administration 145

AGING VETERANS HEALTH CARE ISSUES

TUESDAY, APRIL 23, 1985

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs;
and Select Committee on Aging,
Washington, DC.

The Subcommittee on Hospitals and Health Care and the Select Committee on Aging met in joint session, pursuant to notice, at 9:35 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the Subcommittee on Hospitals and Health Care) presiding.

Present: Representatives Edgar, Roybal, Montgomery, Biaggi, Mica, Evans, Hughes, Kaptur, Mollohan, Penny, Staggers, Rowland of Georgia, MacKay, Sisisky, Manton, Hammerschmidt, Smith of New Jersey, Schneider, Johnson, Ridge, Rowland of Connecticut, Gekas, Boehlert, Saxton, Bentley, Lightfoot, Fawell, Blaz, Henry and Schuette.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. Edgar. Good morning. The joint hearing of the Subcommittee on Hospitals and Health Care of the Veterans' Affairs Committee and the Select Committee on Aging will begin.

Let me begin by welcoming my colleagues both from the Subcommittee on Hospitals and Health Care as well as the Select Committee on Aging. We really look forward to this hearing this morning and we appreciate the fact that we have some additional members here in our hearing room. We hope that everyone will have a full opportunity to raise questions.

I would ask unanimous consent to put in the record a longer statement, and I will proceed by reading this introduction. Without objection, so ordered.[1]

Welcome to the joint hearing of the Subcommittee on Hospitals and Health Care of the House Veterans' Affairs Committee and the House Select Committee on Aging. This joint hearing is an opportunity for these two committees to look very carefully at the issue of the aging veteran. The Select Committee on Aging and the Hospitals and Health Care Subcommittee are both interested in the "graying of America" or the aging veteran. Such glib labels belie a phenomenon which is so large and so complex that it is difficult sometimes to even envision it.

---

[1] See p. 75.

Today we intend to receive testimony which I believe will help us learn the administration's decisions on national policy for health care. I hope these decisions do not simply shift the burden for care from one budget to another and do not create gaps in the kinds of services offered, nor in the eligibility for those services.

In a very real sense, the policies which are implemented by the Veteran's Administration for veterans should interact with policies implemented by other agencies. Since the veteran is growing older at a somewhat faster rate than the rest of the population, and since the VA provides services to a large number of our citizens, there is a special need to investigate the effects and the interactions resulting from changes in eligibility and the range of services offered by the VA.

There will be three general topics addressed today. One topic will be the distribution of resources to meet the needs of the aging veteran within the VA and other Federal agencies.

The budget proposed by the administration for fiscal year 1986 is inconsistent with the estimates of need and medical requirements to meet the needs projected in the VA's own report, "Caring for the Older Veteran." The VA budget and budgets for other health and medical functions of the Federal Government proposed for next year and beyond raise serious questions about the capacity of this Nation to meet both the needs of the veterans and other citizens as they reach the time in life of increasing medical needs. Further, there is alarming evidence of a reluctance to address in a comprehensive way the gaps and overlaps in acute and long-term care available and planned for aging people.

A second topic will be the assessment of the size of the aging population for purposes of resource distribution. In preparation for this hearing, joint letters were sent by Chairman Roybal and me requesting the numbers on which administration estimates of the effects of proposals on health care eligibility are based. These letters were sent to the Department of Health and Human Services, the Veterans' Administration, and the Congressional Budget Office. I would like to insert a copy of this letter into the record at this time. Without objection, it will be made part of the record.

[The letter referred to appears at p. 77.]

Mr. **Edgar**. Late last evening the Health Care Financing Administration and the Acting Commissioner on Aging submitted statements for inclusion in the hearing record.

The third topic is the experience veterans encounter as they seek services. We are particularly interested in these experiences in order to assess both the planning and the implementation of the policies we in the Congress enact and the Federal agencies administer.

We will hear testimony from Dr. Donald Custis and Dr. John Rowe regarding their projections of the array of services for aging and the relationship between the VA and other providers for these services. We will hear the first-hand experiences of those who help aging veterans negotiate the fragmented system of care sometimes available—service officers from veterans service organizations and social workers from the private sector.

We in Congress and the executive branch have the responsibility and the opportunity to face this phenomenon of the aging. It is, indeed, our decision whether to fill a golden pond for our aging citizens or to leave a dry hole. We will talk about it today in a national way, veteran and nonveteran together, and about the dilemmas it presents to health and other professions, to private organizations, and to State, local, and Federal Governments. Surely the range of individuals, organizations and entities involved in this phenomenon, create opportunities for sharing the multiple responsibilities associated with aging. I hope this hearing will start an awareness of the opportunities for sharing.

Before recognizing my colleagues, I want to insert in the hearing record a letter from the Office of Legislation in the Department of Health and Human Services declining our request for a representative from the Department to testify today. I am dismayed at this further evidence of an unwillingness of the administration to comprehensively address the health care needs of aging citizens.

[The referred to letter appears at p. 79.]

Mr. EDGAR. Additionally, on March 14, Chairman Roybal and I requested that the VA, as well as the Department of Health and Human Services' Health Care Financing Administration and the Congressional Budget Office provide detailed analytic data concerning the means test and third party reimbursement. If there are no objections, I would like to include in the hearing record a copy of the VA Administrator's response which I received yesterday at approximately 11:30 a.m., which states that, "The complex analyses you had hoped could be furnished to the committees by April 12 remain incomplete." It remains a mystery to me how the administration can propose such major changes in eligibility when they do not have the relevant data to make the proposals.

[The referred to letter appears at p. 80.]

Mr. EDGAR. The chairman of the Select Committee on Aging, the Honorable Ed Roybal, has been detained at another hearing and will join us later.

Without objection, the prepared statement of Chairman Roybal will be inserted at this point in the record.

OPENING STATEMENT OF EDWARD R. ROYBAL CHAIRMAN, HOUSE SELECT COMMITTEE ON AGING

Chairman ROYBAL. Today's joint hearing is an important and unprecedented event. Over the next 20 years, the number of older American veterans will triple to nine million—well before an increase of this magnitude will be seen for the elderly population at large. This poses a significant challenge to the Veterans Administration and to the Nation in meeting our fundamental commitment to those who served. It also presents an opportunity to respond to the immediate needs of older veterans in a way that will enable us to also provide for the longer term needs of an aging society.

The administration's response to growing numbers of older veterans is simple, restrict their access to care. This is an affront to America's veterans and another in a long line of boken promises. It is ironic, if not tragic, that the administration is turning its back on veterans just as we are celebrating the 40 year anniversary of the return of these same men and women from service in World War Two. We made a promise to these veterans that cannot be broken. Despite this promise, the administration is proposing a means test for older veterans that will only increase their out-of-pocket costs and add to the burden of Medicare. If accepted, more and more veterans will turn to the VA for care, only to find a closed door.

It is our responsibility as advocates, providers, and policy makers to look for creative solutions that will preserve our commitment to veterans while also protecting a rapidly growing population of elderly. Limiting veteran access to care is not the answer. Nor is continuing to plan and provide services on parallel tracks.

There is much that the VA and the community can do together on behalf of all older American's. In this spirit, I look forward to hearing how we can move in this direction, away from talk of means testing.

Mr. EDGAR. I will now recognize the ranking minority member of the Subcommittee on Hospitals and Health Care, who is also a member of the Select Committee on Aging, the Honorable John Paul Hammerschmidt, for any remarks he may wish to make.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

This joint hearing of our two committees provides an excellent opportunity for the Congress to inquire into the special problems that face the aging veterans of our Nation. Both committees have a vital role to play in seeking solutions to those problems. My long time membership on each of them tells me we have a very unique challenge in a most vital area.

Mr. Chairman, medical advances have materially lengthened the lives of our citizens. It has also brought to the vast majority of them a better quality of life and they have made substantial contributions to a more meaningful society. But the aging process also sometimes takes its toll. Those who live longer often have more chronic illnesses, but they also have more acute ones, too.

As the problems associated with the coming of the golden age and the fullness of life come to them, they deserve the best attention that each of us can give. Among all Government agencies, it occurs to me that the Veterans' Administration must play a very critical role. It is a Federal nationwide medical mechanism. Its clientele are select individuals. It is already on the cutting edge of geriatric medicine and it can readily count its future patient universe. For all these reasons, it is proper that our two committees meet to focus on VA's plans to meet the medical needs of the aging veteran. The meeting of those needs can be and, indeed, ought to be, the forerunner of things to come for all Americans as they, too, enter advancing years.

Mr. Chairman, we meet on a critical issue of our time. There will be 9 million veterans by the year 2000. The Veterans' Administration can't possibly cope with the medical infirmities of those who will come to it without having new approaches or by merely extending current practices. It will not have enough money to just build more and more facilities. It must forthrightly adapt to change and reach for new initiatives and new policies.

Mr. Chairman, it is my view that the VA has accepted the challenge before it. Its recent studies have delved deeply into the looking glass of the future. Those studies contain suggestions that will require major actions and decisions not only by VA but by the Congress and, indeed, by all the people of our country. They are options to act upon and to build upon.

Mr. Chairman, our Veterans' Affairs Committee also recognizes the challenge before it. So, too, does the Select Committee on Aging of the House of Representatives. So I congratulate you and Chairman Roybal for bringing us together for this morning's endeavor. Together we can come to grips with the problems of those among us who are entering what ought to be a good and productive time of their lives. Proper medical care and services for them is the challenge before us. I am confident that we will face that challenge squarely and give to it our priorities, our best thoughts, and our best efforts.

Mr. Chairman, I am anxious to hear from our witnesses this morning, to learn from them, and to be stimulated by their testimony and by their suggestions.

Mr. Chairman, I would ask unanimous consent that at this point in the record I be allowed to submit testimony from our colleague on the Select Committee on Aging, Olympia Snowe.

Mr. EDGAR. Without objection, so ordered.

[The statement of Hon. Olympia Snowe follows:]

PREPARED STATEMENT OF HON. OLYMPIA J. SNOWE

Thank you, Mr. Chairman. I want to thank you gentlemen for holding this hearing on the older veteran. It is indeed timely and appropriate to bring these two committees together to consider what is clearly the great challenge facing the veterans administration and we here in the Congress who authorize veterans' programs—namely, the need to decide whether this country will meet the needs of the rapidly growing numbers of older veterans—what some people are calling the veterans geriatric imperative—and, if the answer is yes, to decide how we will accomplish this.

I feel sure that our witnesses today will provide helpful and enlightening comments on H.R. 505, the bill which is on our agenda, and on the Administration's proposal to impose a means test for eligibility for veterans with non-service connected disabilities.

I hope also that at least some of our witnesses, including particularly those from the Veterans' Administration, will provide a critique of the four bills I introduced earlier in this Congress which were designed to improve the ability of the Veterans' Administration to take care of veterans with long term care problems. Three of the bills dealt with Alzheimer's disease, a problem of truly catastrophic dimensions for the individuals and families involved, and for our society, as it clearly indicated by the estimate that up to fifty percent of people institutionalized in nursing homes have Alzheimer's disease or a related neurological disorder. Given that the demographers are telling us that by the year 2000 some two-thirds of older men will be veterans, Alzheimer's disease is going to be one of the major problems faced by this population. The fourth bill, H.R. 1104, would make certain changes in the way the veterans administration manages its health care system, and, in my view, could help the VA better deal with the growing long term care needs of the older veterans population.

In the event that the Administration's witnesses are unable to provide such a critique here, it is my intention to request a written review from the Administrator of Veterans Affairs.

As we all know, the growing geriatric imperative will present special problems to the Veterans' Administration. I will not review the statistics on the changing veterans population. Through frequent repetition, they are becoming well known. What must be kept clearly in focus is that this older population will experience a different mix of diseases and health problems than does a younger population. The kinds of diseases which are characteristic of an older population—coronary and circulatory system diseases, respiratory diseases, cancers, organic brain disorders, including Alzheimer's disease—tend to be chronic, progressive and degenerative, and tend to require long term care.

The central question which therefore must be raised, it seems to me, is whether the Veterans' Administration is now prepared to deal with this long term care burden, or is well on its way to being able to deal with it.

I suggest that the answer is no.

I certainly do not wish to suggest that the Veteran's Administration is not doing good work, or is not thinking hard about the problems presented by its older clientele. In recent years, Veterans' Administration staff have been leaders in developing the fields of gerontology and geriatrics. The VA's training programs help to prepare health practitioners who are sensitive to, and knowledgeable about, older people. And the Veterans' Administration has helped to develop innovative programs which are being used to meet the needs of all our older citizens.

Nevertheless, I think that it is still accurate to say that the Veterans' Administration is not prepared to deal with this long term care problem in an adequate way.

The bill which is on our agenda today, H.R. 505, introduced by Mr. Edgar, seems a step in the right direction. Among other things, its authorization of respite care for veterans suffering from terminal illnesses and of an expansion of the geriatric research, education and clinical center seem worthy of support. I would say, parenthetically, that I hope "terminal illness" will be construed in report language on the bill to include Alzheimer's disease, for it clearly is terminal illness.

I do want you know, Chairman Edgar, that I intend to support your efforts to help the VA cope with the problem of caring for the older veteran with long term care needs and I intend to follow closely the progress of your bill as it moves through committee and to the full House.

I would like to suggest, however, that there is still more which could be done. Early this year, I introduced four bills designed to improve the ability of the Veterans' Administration to take care of veterans with long term care problems. Three of the bills dealt with Alzheimer's disease, a problem of truly catastrophic dimensions for the individuals and families involved, and for our society, as is clearly indicated by the estimate that up to fifty percent of people institutionalized in nursing homes have Alzheimer's disease or a related neurological disorder. Given that the demographers are telling us that by the year 2000 some two-thirds of older men will be veterans, Alzheimer's disease is going to be one of the major problems faced by the population.

My fourth bill, H.R. 1104, would make certain changes in the way the Veterans' Administration manages its health care system, and, in my view, could help the VA better deal with the growing long term needs of the older veterans population.

I want to make a comment or two about this fourth bill. At the present time, the Veterans' Administration loses sight of a veteran when he or she is discharged from a Veteran's Administration facility or a facility on ocntract with the VA. I understand that the VA is initiating a system for keeping track of veterans with service-connected problems who are discharged from VA facilities, and I would like to hear more about that today. It is my understanding, However, that the VA does not keep track of other veterans once they are discharged. The purpose of H.R. 1104 is to give the VA the authority to do this.

I want to stress that this proposal did not emerge like some bolt out of the blue, divorced from the debate on reform of the VA health system. Quite the contrary, in fact. At a hearing on the older veteran held in New Jersey in August 1984 by the Subcommittee on Human Services of the Select Committee on Aging, Dr. Terrie Wettle of Harvard University reported on a project done collaboratively between Harvard and the Boston Veterans' Administration GRECC.

In her statement before the Committee, Dr. Wettle recommended expansion and development of care management for high risk older veterans. She recommended a major demonstration of care management which would include careful assessment at regular intervals of veterans at high risk of heavy utilization of service, and recommended that those veterans be brought into VA facilities for service interventions as needed.

Among other things, she also recommended closer collaboration between the Veterans' Administration and providers of service in the community.

To my way of thinking, the enrollment system which I am proposing with H.R. 1104 would be an integral part of any expansion in the VA's care management system.

A fully developed care management system, and here I am thinking particularly of the enrollment and tracking features of H.R. 1104, would have several benefits for older veterans and for the Veterans' Administration:

It would help high-risk veterans by allowing the Veterans' Administration to closely monitor their status and to intervene at appropriate times; the VA would benefit because such interventions would provide care before the veterans in question had deteriorated to the point where more comprehensive and more expensive care would be needed.

The Veterans' Administration would have a much better understanding of the demands which would be made on it by veterans presently discharged from VA facilities but likely to reapply for veterans services; this would help the VA to better plan for services for this group.

The VA would be better able to establish good linkages and collaborative relationships with community agencies which are serving older veterans.

Finally, Mr. Chairman, I hope the hearing today will be an opportunity to get a critique of these bills from the Veterans' Administration and from other interested parties. In the event that the administration witnesses are unable to provide such a critique here, it is my intention to request such a review from the Administrator of Veterans Affairs.

Mr. **Hammerschmidt**. I would also request that the record be open for all other Members who would wish to submit testimony.

Mr. **Edgar**. Without objection, so ordered.

And, without objection, we will insert in the record at this point a statement from Tommy Robinson, our colleague from Arkansas, who is not able to be with us because of illness today. Without objection, that will be made a part of the record.

Prepared Statement of Hon. Tommy Robinson

Mr. Chairman, let me say that I am especially pleased to be present at this hearing today. I have the privilege of serving on both the Veterans' Affairs Committee and the House Select Committee on Aging.

The health care needs of all senior citizens is of vital concern to me. But the special population of seniors—those who have served this nation in the military—is rightfully the focus of a joint hearing between these two House committees.

We in the Congress are about to get down to the serious business of putting together a budget for fiscal year 1986. The proposals that we have seen so far are disturbing with respect to the impact they will have on seniors and especially senior veterans.

Medicare has been under attack since 1981—and has been slated for another round of cuts under the President's proposed budget for FY 86. Now we are faced with an attack from another front as the President has proposed means testing for nonservice-connected veterans. It seems reasonable to assume that either costs are merely going to be shifted from one program to another (Medicare to VA programs or vice versa) or we are going to see our senior veterans doing without the health care that was promised them when they entered the military.

Moving monies around from program to program is rather like robbing Peter to pay Paul.

One final note from me before we hear the testimony of the panels—and I must say that after glancing at the list of witnesses, I feel certain that we will have an informative time here today—is to mention a fact that many people don't realize—Arkansas is second only to Florida in the number of senior citizens—on a per capita basis. And Arkansas' second congressional district has over 92,000 veterans so my interest is more than academic.

Again, Mr. Chairman, I congratulate you for convening this hearing this morning.

Mr. **Edgar**. Are there any of my colleagues who have an opening statement? I yield to my colleague from Pennsylvania.

OPENING STATEMENT OF HON. GEORGE W. GEKAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. **Gekas**. Thank you, Mr. Chairman.

I simply want the record to reflect that I am not as quick to adversely criticize the Veterans' Administration or any part of the administration as the chairman did in his opening statement. Rather, I would like these proceedings to begin on an open and fair and nonpartisan basis, for which they were intended, and that any innuendo that the Veterans' Administration or the administration is not willing to cooperate with whatever final product comes from this hearing is not warranted. Therefore, I would hope that we can begin and conclude these hearings with whatever recommendations we want to make to the Congress or to respond to the President or to the Veterans' Administration in a fulfilling way. So I hope we start off on the right foot.

Mr. **Edgar**. Well, as the chairman, I want to state—and I had not intended to underscore my opening frustration—that I have been chairman of this Hospitals and Health Care Subcommittee for about a year and a half, and I can tell you that I have been very frustrated with the Health and Human Services Agency which has, in fact, refused to testify at these joint hearings, given ample warning.

The question that we have before us is whether or not we change clear eligibility and whether or not those who are eligible for veterans' services over the age of 65 will have to comply with a means test and whether or not we will change present policy to provide for third party reimbursement for veterans.

If we, in this committee, are going to do our job, we need data. The administration has come forward on February 4 with a budget. The Senate committee has, in a knee-jerk response, responded to that budget and provided for inclusion in that budget a savings of some $400 million projected by instituting third party reimbursement and a means test for those over the age of 65.

This subcommittee and the Select Committee on Aging are very interested in the impact of these changes on the aging veteran. Not to have the administration testify, and not to have clear evidence of what the impact will be, or documentation of that $400 million, is a problem. In my opening statement, the reason I drew attention to that was that I am pleased that the VA is here, but I am disappointed they are here without numbers and data, and I am very disappointed that the Health and Human Services Agency has chosen not to testify.

We had hearings before our subcommittee earlier this year, at which point the Administrator for the VA and the Chief Medical Director were present, and the proposals were laid out. We were told at that time that we would be given ample evidence, data, to make the decision that we have to make. Here we are before this setting, willing and ready to listen, as carefully and as creatively as we can.

I would hope that the Office of Management and Budget, Health and Human Services, and the VA, would be forthright in coming forward to this committee and to the members of this committee with documentation. Otherwise, it may be necessary for us to reject out of hand their proposals to radically change the eligibility for veterans without knowing what data, what criteria, they base their decisions on. So that's the reason the chairman raised the concern and the frustration in his statement, and I stand behind that at this point.

Mr. **Hammerschmidt**. Will the gentleman——

Mr. **Gekas**. Mr. Chairman, I will retain my time, if I may, and then yield to John Paul, if I may.

There is no indication that the Veterans' Administration is not going to provide information to you. It is simply, according to the chairman's statement, that at this time they cannot provide it because they are not fully aware of all the complexities required to prepare that report. You may accept that any way you want, but I do not believe that you can state categorically that that is a failure to cooperate. I simply want that inserted in the record.

I yield to my colleague, John Paul.

Mr. **Hammerschmidt**. If the gentleman will yield briefly, it appears we're on the second bell on a vote——

Mr. **Edgar**. No, no. At a quarter of we recessed for 5 minutes. We have just gone into session for today, having ended yesterday's session. We're beginning a discussion of the rule on Nicaraguan aid.

Mr. **Hammerschmidt**. I see. Well, I thank the gentleman for yielding.

I just wanted to make a comment—and I don't have any way of second guessing the Administration's motives and their actions—except to say they may recognize that this is a rather unusual hearing. We have one committee here of authorizing jurisdiction, the Subcommittee on Hospitals and Health Care, and we have another committee that has absolutely no legislative jurisdiction. They certainly have a right to access information and they have an interest in it. But we do have sort of a mixed bag here this morning.

It could be for that reason that the Administration has delayed in sending the information that we seek. I don't know that, but it would seem logical.

I thank the gentleman for yielding.

Mr. **Edgar**. I will reclaim the time and simply say that we have given the VA and Health and Human Services very ample time to present some data. They brought their budget forward on February 4. They are asking us to change public policy. If we are going to change that public policy, we need to base it on some facts.

I now ask our first panel to come forward. We have two national service officers from the Disabled American Veterans, and the director of veterans services, Veterans of Foreign Wars. Would they come forward at this time—Mr. Aviles, Mr. McLeon, and Mr. O'Neill. Gentlemen, we are very pleased to have you here.

I understand we have one additional opening statement this morning—I called for those earlier—so let me yield to my colleague for an opening statement.

OPENING STATEMENT OF HON. THOMAS J. MANTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. **Manton**. Thank you, Mr. Chairman.

Mr. Chairman, I recently held a town hall meeting on issues of concern to veterans. Throughout the meeting, my constituents expressed their grave concern regarding the administration's proposals affecting America's veterans. My constituents are particularly concerned with the proposal to limit the health care provided by the Veterans' Administration by requiring a means test for nonservice-connected veterans over age 65.

In the next few years we will be seeing a graying of the veteran population. There are 11.3 million veterans alive today who served in World War II. Within the next few years, most of these veterans will be turning age 65. By the year 2000, the number of older veterans will triple to 9 million. The Veterans' Administration will be facing the challenge of meeting the needs of the increasing number of older veterans.

Today's hearing will aid us in developing a more effective and equitable approach than the one which the administration has proposed. Typically, the administration's response to this challenge has been to propose a means test rather than offering a comprehensive approach to meeting the increased need of health care by our veterans. This response is inadequate, ineffective, and inequitable.

Rather than looking at the ways the Veterans' Administration and the nonveterans community can meet the growing needs of older veterans, the administration has simply proposed a plan that would effectively shift the costs to another Government program, Medicare, which is already overburdened. This is not a cost-effective approach nor is Medicare a comparable replacement for VA health care. If the costs are merely shifted to another program, where are the cost savings the administration envisions?

At this important hearing today we will be examining the effect of the Administration's means test proposal on the veterans and on the Medicare system, but we will also be examining some alternative approaches to meeting the future needs of our veterans, instead of just ignoring the problem. Perhaps the Administration should be also developing programs to help veterans meet their changing health needs by developing support programs and home health care.

I look forward to hearing the witnesses' views in this regard, as well as learning the results of the analyses performed by the Veterans' Administration, the Department of Human Services, and the Congressional Budget Office. When the country asked our veterans to serve, they responded to the challenge, and I believe we must be prepared to do the same.

Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you very much. Are there any other opening statements?

Mr. Schuette.

OPENING STATEMENT OF HON. BILL SCHUETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. **Schuette**. Mr. Chairman, fellow committee members, witnesses and guests, I am pleased to participate in this joint hearing of the Select Committee on Aging and the Committee on Veterans' Affairs. This morning, we shall address the ongoing health needs of America's aging veterans. It is estimated that by the year 2000 the number of veterans will triple to approximately 9 million. Two out of every three males over 65 will be veterans. And how will these veterans be assured of adequate long-term health care under the present constraints? We are here to explore the alternatives that have been proposed to ensure care for our veterans. We must plan for the needs of America's aging veterans. It is our duty to provide health services for those brave men and women who served without hesitation for our Nation.

America faces a crisis even today in her efforts to provide medical services to veterans. The problem in providing these services is twofold: access and cost. Literally thousands of veterans are turned away each month in the United States by VA authorities simply due to the lack of resources, manpower, and funds. If we cannot help those veterans presently seeking health care, how may we conceivably expect to serve three times as many veterans at the turn of the century?

If the Veterans' Administration facilities cannot accommodate the veterans, where can they turn? Private hospital services are costly and overwhelmed with patients. If we are to care for our veterans through a Veterans' Administration, then we must meet the needs of the Veterans' Administration. If we provide health care to veterans through some alternative channel, such as Medicare or Medicaid, then we must support those programs. We cannot stand back and wait until the year 2000 to address the concerns of America's veterans.

There are proposals to reform the VA health care services now and in the year 2000. Those proposals include the implementation of a means test, cost-sharing and other approaches. We must act swiftly to develop and implement reforms so that the veterans of today and those of tomorrow may obtain adequate health care.

I am anxious to hear the testimony from our witnesses and to begin our inquiry into the concerns of the aging veterans. I would like to welcome one of the panelists from the State of Michigan, Mr. Raymond G. O'Neill, director of veterans services.

Thank you Mr. Chairman.

Mr. **Edgar**. We will now hear from our first witness, Mr. Albert Aviles, who is the national service officer, Disabled American Veterans, from Los Angeles. Welcome to our committee this morning, and we look forward to hearing your statement.

STATEMENTS OF ALBERT L. AVILES, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS, LOS ANGELES, CA; CHARLES M. McLEOD, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS, ST. PETERSBURG, FL; AND RAYMOND G. O'NEILL, DIRECTOR, VETERANS SERVICE, STATE OF MICHIGAN, VETERANS OF FOREIGN WARS

STATEMENT OF ALBERT L. AVILES

Mr. **Aviles**. Thank you, Mr. Chairman.

It is indeed a pleasure for me to appear before you today to present testimony on the issue of delivery of services to veterans from the Veterans' Administration nonveterans community for long-term, nonacute care.

I have submitted a statement which, in essence, spells out the problems that we have experienced in Los Angeles. More and more we're seeing veterans coming into our office complaining about the noneligibility that they're experiencing in trying to obtain care from the Veterans' Administration, especially in the nursing home placement area. A common complaint that we hear is that they are turned away because the Veterans' Administration commonly tells them that there's no bed space available. That, to me, is incomprehensible, because once we start making calls, all of a sudden the beds appear. It seems like every time a veteran goes to apply for care, if he's an older veteran and he is in need of nursing home placement, the red flag goes up, so to speak. They look for ways not to admit him.

Under the present structure in the Veterans' Administration, you have to be admitted into the VA facility before you can be placed in a nursing home unit, or referred to the contract nursing home program.

If they are erroneously admitted for placement in a nursing home facility, they have no choice but to refer them to the department of public social services in Los Angeles, which normally means that they will be sent to a community nursing home, which is substandard. I know from my own personal experience in dealing with the nursing home facilities that they are not really fit for the veteran population.

Under the Contract Nursing Home Program of the Veterans' Administration, State-approved facilities do have to be approved by a Veterans' Administration team. In the social work services the VA does a very fine job in trying to place these veterans, and they always follow up. But I still believe that the Veterans' Administration is best suited to provide the care for the aging veteran. As these veterans grow older, their needs are going to grow more acute.

It was stated earlier in the statements that they do require care for chronic conditions. But the acute conditions are also going to be more and more. They are getting older, and as you age, the process of aging brings along the conditions which require this care.

Let me get back to the contracting nursing home. We experience problems when they are discharged from the hospital and it is assessed that they do require nursing home care and are going to put them on a contract. The contract is for 6 months for non-service-connected conditions. That raises a little bit of anxiety amongst the family members. The family members commonly ask us, "What will we do after the 6 months? Who's going to pay for this? We'll have to sell our house." They don't have the resources to pay for this care, especially if a veteran is older and his spouse is just as old as he is. They are living on a fixed income. When you're living on a fixed income and all of a sudden you're faced with a catastrophic condition that is going to eat that income, even with Medicare, the amount of money they are going to have to lay out to keep that veteran placed in a nursing home facility in the community would just about wipe them out.

As I stated earlier, the Veterans' Administration nursing home facility units are, in our opinion, the best, mainly because they have the support services, they can provide rehabilitative medicine, and they have a valuable asset which I believe is very valuable, and that is VAVS Program, the volunteer service of the Veterans' Administration. Our organization is very active in that regard and we provide a valuable service to the VA.

In closing, I would like to state that these veterans, when they were called on and went off to war, they were told—and we hear the story every day—"I was promised I would be taken care of when I came out, and now we're being told that we're not eligible for one means or another. It's not fair. Why did I go and what did I fight for?"

It is very hard for us in the field to face an older veteran, especially the spouse, and tell her there is not much we can do at this point until we change the law, or until the Veterans' Administration opens their eyes to the problems of the aging veteran. I would just hope that through the testimony here today, through your actions here in the Congress, that you open your arms and open your hearts to these veterans who are requiring the care and who are going to require it more and more in years to come.

I would like to thank you again, Mr. Chairman, for allowing me to make my statement.

[The statement of Albert Aviles appears at p. 91.]

Mr. EDGAR. Thank you very much for your statement.

The full text of all three statements will be made a part of the record, without objection.

We will now hear from our next witness, Mr. McLeod.

STATEMENT OF CHARLES M. McLEOD

Mr. McLEOD. Thank you very much, Mr. Chairman.

Since you have accepted my written testimony as part of the record, I do have some verbal testimony I would like to give covering some of the aspects of medical treatment for veterans and their dependents, especially as it pertains to the State of Florida.

Mr. Chairman, as you pointed out in your opening remarks, one of the big problems that we're facing in the VA system itself throughout the country, and particularly in the State of Florida, is the problem of the aging veteran. Florida, at the present time, leads the Nation in the actual average age of its veteran population. We're in a position now that the VA system will find itself in probably in another 5 to 8 years from now, so the problems that we're experiencing now actually will turn out to be some of the solutions that the VA will be relying on in the years to come to solve its aging veteran population.

Mr. Chairman, Florida is unique, as you well know, in terms of the number of veterans who choose to come to our State, to set up their final years, to enjoy retirement life—the good life, as we call it down in the sunshine State. But one of the problems that becomes very apparent to these people once they arrive is the somewhat restrictive medical treatment they're eligible for. There just is not sufficient space in our VA medical facilities for either acute care or for long-term nonacute medical treatment.

I was very pleased when I received your letter to appear and testify today, primarily because of the fact that I felt that now the committee was taking a serious look at the problems that are affecting these people, this aging veteran group that we're trying to deal with.

One of the big things that I see and hear quite often from the veterans that I represent in the State of Florida is that we read in the newspapers and we hear on TV about the administration's proposal for increasing the budget for defense, buying new weapons systems, changing new weapons systems, continuously making improvements in our defense posture. Yet I think—and a lot of veterans agree with me—that one of the big things we have overlooked in this situation is the key element in our national defense, which is the people that fly the planes, carry the guns, and do the job that has to be done with the weapons systems that are purchased.

The veteran himself is one ingredient that has remained very constant throughout the entire history of this country. He is the person who is called upon to go in and do the job when it has to be done. Unfortunately, in a lot of situations, he's the first the system has forgotten about once the war ends. The veterans in Florida, the majority of whom right now are World War II veterans, the majority of whom are reaching that age where they are now looking forward to being able to enjoy some of the fruits of their long labors, these people have reached the point where they are sitting back now and are saying, "Well, I've got so much money coming in, and I've got a little VA check coming in; I've got a small Social Security check." If they're lucky, they were able to work for some company that provided some type of pension program to supplement these other sources of income. But basically, the common denominator in all these people is the fact that they have a fixed income that is not going to change. It's going to stay constant.

Yet, the one big thing that comes about that really affects these people's planning more than anything else is the actual cost of medical care. Availability is one thing, if there is medical services available, both long-term and short-term acute type care, but cost is a big problem with it. The veteran was promised in World War II and years after that if he became in need of medical treatment the VA would be there to provide that care for him. Unfortunately, specifically as it pertains to the State of Florida, this has not been true. Right now Florida enjoys a utilization rate of its facilities probably second to none in the country. People are standing in line to get into VA facilities to obtain treatment.

We refer to using private resources that may be available to fit the demands of this long-term, nonacute care situation. Well, particularly in Florida, there is a critical shortage of these private facilities that can handle the veterans' population. As my fellow service officer from California pointed out, the VA is making an effort to take veterans into contract-type nursing facilities outside of the system to provide some access to long-term nonacute care for them.

However, the problem itself is so complex and so detailed, that you take a veteran that comes in—and he's always been working under the assumption that "when I need it, the VA will be there and will provide it for me." Then the day comes when he has to have this nursing home care. He just cannot take care of himself, and his family is sitting there trying to figure out what they're going to do with him. All these years they have been laboring under the assumption that the VA would provide that care.

They come into the system, and what happens? If they're very lucky, if they're very lucky, they will get referred out on a contract. But by and large, the VA says "Well, we don't really think you need this nursing care; we don't think it is something that will do you any good. You go home and find some other means of providing that care for yourself." So what happens? The family is back in the situation of the kids having to come up with money, the spouse talking about selling the house or cashing in insurance policies, or figuring out how the pension plan as provided by their employer can be cashed in so they have enough money to meet these $1,800 or $2,800 a month long-term care bills.

The problem itself has no really easy solution to it. We keep saying a lot of times that people throw good money after bad, to create more and more programs that don't really solve any problems. But the fact remains that right now there is a critical problem facing veterans, especially the older veteran. He has reached the time when he needs this care, and he has all of a sudden discovered it's not available to him. It's just not there.

So, Mr. Chairman, on behalf of myself and the veterans in the State of Florida that I represent, I would certainly express to you and all the members of this committee my sincere appreciation for the interest you have shown in this problem and I look forward to some solutions come out.

Thank you.

[The statement of Charles M. McLeod appears at p. 93.]

Mr. EDGAR. Thank you very much.

Our next witness is Mr. O'Neill.

We look forward to hearing your statement.

STATEMENT OF RAYMOND G. O'NEILL

Mr. O'NEILL. Mr. Chairman and members of this joint committee, my name is Raymond G. O'Neill. I am the State veterans service director, Department of Michigan, Veterans of Foreign Wars of the United States.

The purpose of my presence here today is to share with you the views of a service officer who works on the line—the eyeball contact with the veteran and his familiy—and I have been doing it for the past 33 years.

Although the thoughts I express will be based on my experience in the State of Michigan, they certainly will be reflective of the views of my fellow VFW service officers throughout this Nation.

We have a crisis on our hands. There are thousands of aged veterans out there who need special care, and the Veterans' Administration is unable to meet this demand. Additionally, there is a movement in the private medical sector to force the VA to accept medical care patients that are destined to become nursing care cases.

The VA recently released a report titled "Caring for the Older Veteran," an excellent presentation. In that part related to extended care strategy, the VA has rejected goals with completion dates by the year 1990 and 2000. This document should have been completed 10 years ago with projected goals and completion dates by the year 1985. If it had been accomplished, we would not find ourselves being overwhelmed by a rapidly aging veteran population.

It is necessary to point out that the VA, within their present authority, is doing everything within their power to meet this challenge. However, suddenly, and without warning, an unforeseen development has occurred that threatens to crush the VA's acute medical care program.

I am talking about the private medical sector's practice of what is referred to as "dumping," brought about principally by DRG's. In this respect, I have attached, Mr. Chairman, to this testimony in the form of evidence, referrals to the VA medical centers at Saginaw and Ann Arbor, together with an article related to this subject.[1]

In your review process, please note the outright deceit shown by some of the community hospitals in their advisement to the VA medical centers as to the condition of the patient. To illustrate, let me just quote one.

Case No. 1 in the attachment shows the VA medical center in Saginaw had a patient that would be referred to as follows: "stroke victim, left hemiplegia, yet stable, able to talk and swallow, no catheter or IV's." Patient condition upon arrival at the VA medical center: "Patient found to have IV's infusing in right arm, slurred speech, left side weakness."

The cause of the dumping dilemma—and it does not take much imagination as to why—is the dollar bill. For example, you can readily appreciate that if a veteran was admitted to a private hospital under a particular diagnostic code, that provided that the normal length of stay for that particular illness, say, was 22 days, with a cost factor of $10,500, and the hospital discovers after, say, perhaps the 12th day that it is going to take perhaps 45 days to complete his period of hospitalization at a cost of $25,000, immediate efforts will be made to transfer that patient to the local VA hospital.

The Veterans of Foreign Wars feels that the Medicare regulations as it relates to the DRG's must be examined as to their impact on the VA and appropriate changes be made. This nightmare could eventually destroy the VA's ability to deliver acute medical care.

Earlier I indicated that the VA's extended care capabilities cannot meet the demands of the eligible. In this regard, I do not want to leave a negative impression with the committee of my feelings for the Veterans' Administration. It is quite to the contrary. I hold them in high esteem. For years I have worked on the line with their medical delivery people and I have always found management and the medical personnel as being very capable, concerned, and compassionate.

In respect to my comments that the VA was 10 years late in releasing it's report entitled "Caring for the Older Veteran," it is only fair and proper to state that during the period of 1975 to 1978 the VA established eight geriatric, research, education and clinical centers. The VA was in step with the times. The VA had the foresight and was out to do something about the aging problem of not only the veteran but, in the process, to develop a plan to care for all aging Americans.

In 1980 the VA requested, and the Congress, in their wisdom, authorized 15 centers. But there was no implementation. Decremental budgeting took care of that, despite the fact that at the time 27 percent of all American males over 65 years of age were veterans.

Finally, in my opening statement I set forth the contention that there were thousands of veterans out there needing nursing care, and I am not one who believes in the myth that old age automatically brings illness. However, we do know that national figures show that 1 out of 20 individuals 65 or older live in sheltered institutions.

---

[1] See p. 96.

In the Detroit metropolitan area, the VA medical center in Allen Park has a catchment area that covers 505,000 veterans. And of this number, we have approximately 200,000 World War II veterans, with an average age of 64 years, and an additional 4,500 World War I veterans with an average age of 89 years.

This center, a 539 general medical and surgical hospital, has only 72 nursing care beds and a community nursing care budget that permits only 86 beds on a daily basis. The cited figure of 1 out of 20 indicates that within the next 12 months the Allen Park catchment area will have over 10,000 veterans in need of nursing care.

We have a crisis on our hands, and we can't wait for the year 1990.

Mr. Chairman, I would like to include some additional information for the record.

Mr. **Edgar**. Without objection, so ordered.

Mr. **O'Neill**. This concludes my testimony. I would be very happy to answer any questions.

[The statement of Raymond G. O'Neill with attachments appears at p. 95.]

Mr. **Edgar**. Thank you very much for your statements. We look forward to having the text of your full statement in the record at this point.

I'm curious—if you could respond to just a general question—in terms of how many veterans you see on a month-to-month basis that are being turned away from VA health care in your areas or regions.

Mr. **O'Neill**. In Michigan, Mr. Chairman, it is hard to get a pulse on exactly who's being turned away. The eligibility of the Veterans' Administration for nonservice-connected, the medically acute care case, they must get in the system and then we work them into the 72 nursing care beds we have at Allen Park, or into the community nursing care program. Those veterans we have come in contact with after the fact, they have already gone into a private hospital and have come out, there is no way we can work them into the VA Nursing Care Program.

I illustrated Detroit with 10,000 potential veterans by the end of this year. If you use the 30 percent of veterans that use the VA system, about 3 million veterans, and equate that with that 10,000, we would say we would have 3,000 available. Within 5 years, with the planning of the Veterans' Administration, it would only give us about 300 nursing care beds in that area by the year 1990. So it is hard to directly reply. We have them, but I couldn't give you numbers.

Mr. **McLeod**. Mr. Chairman, in response to your question, I think basically one of the big problems in answering a question such as that is having to realize the fact that quite a few veterans have a tendency that, when they come to an agency, that they perceive to be an agency set up solely for the purpose of serving them, and they receive a negative response from that agency, they have a tendency to assume that's the correct answer and that's the final decision and they walk away.

But in terms of the actual numbers that we talk to, who are primarily complaining about medical treatment, or in this case, the lack of medical treatment, it probably runs somewhere in the neighborhood of 25 to 35 percent of the people that we actually have contact with in the field, both in terms of their being denied adjunct treatment on an outpatient basis, being denied admission to VA hospitals.

In fact, one particular case comes to mind that happened in my area very recently. A veteran reported to a VA emergency room at one of the hospitals at 4:59 in the afternoon. He died in that same emergency room at 8:30 that evening, still waiting in the emergency room.

So, you know, to answer the question as to how many complaints you get regarding lack of medical treatment, there's thousands of them, most of whom we never hear from because they just accept it.

Mr. O'NEILL. Mr. Chairman, I just might add to qualify, we don't get any complaint in that direction, we in the State of Michigan. What we're talking about, if you talk to the Veterans' Administration, they receive telephone calls asking for nursing care, but they're not eligible under the rules of the Veterans' Administration, under their eligibility requirements. No log is kept, regrettably. I don't know how many calls come in. I'm talking about what we service officers encounter in the field are the cases that do not meet the eligibility requirement. They're nursing care and we have to address them in the future, to make these beds available.

Mr. AVILES. Mr. Chairman, I would say that on an average I personally would experience at least two to three a week. Now, I have nine other associates in our office that experience the same problem. Commonly we get, as I stated earlier, the complaint that they are advised there are no beds available.

Well, we place calls to our department service officers to work on the facilities that we have in the Los Angeles area. Miraculously, all of a sudden a bed is found. We don't understand this, but they are found. But we're talking about the veteran who doesn't come to a service organization. What about them? I would venture to say there are hundreds. As Mr. McLeod stated earlier, those that we come in contact with, normally we can help. But there are those who don't come to us, who just accept the fact that they hear it from the authority "you're not eligible," or "we have no bed space," and they walk away.

Mr. EDGAR. The Veterans' Administration indicates that they turn away about 20,000 veterans a month from veterans' facilities. A portion of those 20,000 are aging veterans.

If, on the one hand, you take the testimony that each of you have given, which is that we have a growing number of aging veterans who are in need of nursing home beds, geriatric care, and hospital health care, and if you take on your side the aging report which the VA has published, as indicated by Mr. O'Neill, probably late—we call it the late, late aging report here on the committee—and if on your side you put the weight of the aging veteran population, the numbers that are being turned away, the lack of beds and the lack of facilities, why, then, do you speculate on the other side that the Office of Management and Budget would submit a budget that would want to restrict or shrink the size of the VA at this very time in history and reduce eligibility for those over the age of 65?

Do you have any understanding as to why we would have this seeming contradiction of a large need, as you have described, and lessening of services, particularly for the aging veteran?

Mr. Aviles. Well, I believe it's the administration's insensitivity to the problem. They don't realize what's going on out in the field. If they came out to the field, they would see first hand the problems they would encounter and that there is no justification for a reduction in budget money. They need more money.

The VA does an admirable job with what they've got. I can't put them down for what they do with the moneys they receive. They go out of their way. As I stated earlier, I think they're just a little insensitive to the issue.

Mr. Edgar. Does anyone else want to respond to that?

Mr. O'Neill. Yes, Mr. Chairman. You mentioned the 65-year age level, and I know the Veterans' Administration, I believe, will be in support of maybe some changes that could be made in the law on the ability-to-pay aspect. We, in the VFW, haven't had a chance really to discuss it within our own ranks as to what our position will be.

But on the reduction of funding, that's putting their heads in a bag. The problem is there. We should have addressed it a long time ago, as I indicated in my testimony.

You know, you look at these figures, and you see 11.2 million World War II veterans alive today, and we talk about our ranks. We've got 4 million over 65 years of age, and then the VA gives a projection by the year 1990 this will go to, say, 7 million, and the year 2000, 9 million. You get all these staggering figures. The World War II veteran, there will only be 4 million of us left by the year 2000. We need nursing care now.

So the money situation, Mr. Chairman, it's not right. We spend it on defense—and I'm a strong supporter of defense, and war is part of the cost of defense. Nursing care is part of the medical problem. We should have the funding now. I know it takes an orderly process to develop construction funding and staff and everything, but the crisis is here now.

Mr. Edgar. Thank you.

I yield to my colleague, John Paul Hammerschmidt.

Mr. Hammerschmidt. Mr. Chairman, do we have a vote on now?

Mr. Edgar. We do have a vote.

Mr. Hammerschmidt. I want to thank all these fine witnesses.

Mr. O'Neill, let me converse with you first. In your 33 years as a veterans service officer, I know you have rendered a lot of service and I congratulate you for that.

Mr. O'Neill. Thank you, sir.

Mr. Hammerschmidt. And I know you have seen a lot of changes in the VA. I notice that your grievance on dumping isn't with the VA; it's with the system under the DRG Program that's evolved in recent years to try to have hospital cost containments, which has been somewhat successful, but you get some bad cases and horror stories out of that, and I know there needs to be some adjustment.

But your grievance there really is not with the Veterans' Administration.

Mr. O'NEILL. No, sir.

Mr. HAMMERSCHMIDT. You remember as I do, that back in the late sixties there were 2 or 3 million outpatient cases a year that came to the VA. Then Congress opened up the system a little bit and they allowed preoperative and postoperative cases to come in, and that expanded it a little more, and then we put in provisions to obviate the need for hospital care. These provisions really opened up the system. Now we're trying to handle 18 million visits a year, as compared to the 2 or 3 million just a few years ago. So you have seen a lot of improvements in the services to all the veterans.

Mr. O'NEILL. Yes, sir.

Mr. HAMMERSCHMIDT. Let me turn to Mr. Aviles, who said in his statement "Unfortunately, the VA budget does not permit total care for all veterans." I'm not sure it's the VA budget. It may be the intent of Congress, realizing that there are certain budget constraints and certain abilities of this Nation to care for the veterans—and they must always, of course, care for their service-connected veterans, and to the degree possible, must try to accommodate all veterans' needs.

But that was never a total commitment made by the Congress; therefore, we are struggling with this fast change to an older veteran population.

There are three types of nursing homes, as you know. We have VA inhouse, which has about 40 percent of the load; we have the contract VA system which carries about 40 percent; and then you have State homes, 20 percent. Congress has requested an increase from $22 million in the project budget to $35 million for State homes. It's one of the least expensive ways in the system to take care of aging veterans' needs.

So I only comment on those things. We have a lot of members here and I don't want to take time with questions really. I have one short question that I would like to ask, perhaps to Mr. O'Neill, because of his long time experience.

Do your surveys and does your experience show that very many affluent veterans are in the VA system?

Mr. O'NEILL. No, sir. Our findings would be right along with the Veterans' Administration, what they released, about 89 percent cannot pay for these services.

You will find the older veteran, because of Medicare, there's a high rate of insurance coverage, maybe 95 percent. But in direct answer to your question, no, sir.

Mr. HAMMERSCHMIDT. Thank you.

Mr. Chairman, I would ask unanimous consent that we be allowed to present questions to our witnesses for their response in writing.

Mr. EDGAR. Without objection, so ordered.

I would like to correct for the record just one statement that my colleague made, I think inadvertently——

Mr. HAMMERSCHMIDT. I could correct that myself. I was going to correct it for the record.

Mr. EDGAR. That is, in 1985 we spent $34.5 million on the State Veterans Home Program, and the administration has asked for a decrease to $22 million for 1986, rather than an increase.

Mr. HAMMERSCHMIDT. Our committee has asked for the increase.

Mr. EDGAR. Yes.

Let me yield 20 seconds to my colleague from Florida and then we will recess for 10 minutes.

Mr. MICA. Mr. Chairman, if I may just commend you for holding these hearings. I just want to add my concern, as I have said many times, the concerns over Florida veterans and the number moving to Florida—and I won't even say it here today. But I would just add that all of the resources that are being pressed, if you put them into the picture of the geographic distribution that is changing to the South and to the Southwest, as well as the age demographic distribution, it is compounded many times over in States like Florida, and I understand California and Arizona, and I didn't say the number——

Mr. PENNY. Would the gentleman yield?

Mr. MICA. I would be happy to yield.

Mr. PENNY. I had forgotten. How many veterans per month move to Florida? [Laughter.]

Mr. MICA. There are 5,000 veterans a month moving to Florida.

Mr. EDGAR. I yield to my colleague from New York for a unanimous-consent request.

Mr. BIAGGI. Mr. Chairman, I ask unanimous consent to have my opening statement entered in the record.

Mr. EDGAR. Without objection, so ordered.

[The statement of Hon. Mario Biaggi follows:]

STATEMENT OF HON. MARIO BIAGGI

Mr. BIAGGI. I want to commend our distinguished chairman for conducting this hearing today on the current and future needs of our changing veterans population. I also believe that it is critical that we work together with our Veterans Affairs Committee, especially with Bob Edgar, who has been a leader in Congress in this area.

Surely, our joint resources will help to produce the best kinds of responses to caring for the health care needs of our veterans.

There is a critical need in my own State of New York—where there are 1.9 million veterans, including 834,000 from World War II and 22,000 from World War I.

My Subcommittee on Human Services conducted the first hearing on this issue last year in New Jersey. At that time—I called for the creation of a new position within the VA—Deputy Administrator for elderly veterans.

While that proposal has not received strong support—I believe that the issue it raises—that being high visibility for the oldest veteans in need of health care—is still viable.

In that light, I contacted the VA last year and asked them to respond to a number of questions regarding linkages of VA and non-VA services.

In that response, Mr. Chairman—which I ask to have included in the record of this hearing—Administrator Walters notes that in 1982—an interagency agreement was signed with the administration on aging and a number of aging organizations. The primary purpose of the document is to share resources and information.

I have not seen any results of that agreement to date—and hope that this hearing will spark some life into that document.

Thank you againt, Mr. Chairman, for calling this hearing and I look forward to today's testimony.

Mr. EDGAR. The committee will stand in recess for 10 minutes.

---

[1] See p. —.

[Whereupon, the joint committees were in recess.]

Mr. **Edgar**. The subcommittee and the Select Committee on Aging will resume its hearing. We appreciate the patience of our witnesses today.

I yield to my colleague from Pennsylvania, Mr. Gekas, for questioning.

Mr. **Gekas**. Thank you.

Mr. Aviles, at one point, in answer to one of the Chairman's questions, said that he felt the administration was insensitive to the needs of the veterans. I am disappointed at that kind of an answer when over the years, as has been demonstrated a hundredfold, the concern and the benefits and the congressional action and administrative proposals over the years have been, I think, very sensitive and responsive to the needs of the veterans. There isn't anyone in Congress or anybody in the White House, in my judgment—and I don't think Mr. Aviles really feels—who wants to throw the veterans to the wolves. The national problems are immense, I know Mr. Aviles recognizes, and he knows that the economy is the single most important feature of making sure that all these benefits are strewn among our populace where they are deserved, and that the immense problem of the budget deficits have to be met so that the economy can be made healthy, so that the benefits to our populace can continue to be distributed as warranted.

That's a different set of problems. To say the administration is hamstrung with money problems, that's one thing. To say they're insensitive is just a little too much, is it not, Mr. Aviles?

Mr. **Aviles**. Well, Mr. Gekas, I wasn't prepared to come here and discuss the economy with you. However, I believe personally, from my conversation with veterans on a daily basis, that the general feeling of veterans, as a whole, is that this administration at least is a bit insensitive to their needs.

Mr. **Gekas**. How about you, Mr. Aviles?

Mr. **Aviles**. I personally feel that in a sense they are, because how can the Office of Management and Budget, for example, propose the various cuts in the various programs and propose a means test for veterans when their need for care is now, and it's going to get more acute.

Mr. **Gekas**. Don't we have a means test now, Mr. Aviles, for certain aspects of Veterans' Administration care?

Mr. **Aviles**. Yes; you do.

Mr. **Gekas**. Are you opposed to that means test that is already in place?

Mr. **Aviles**. Yes; I am.

Mr. **Gekas**. Then what you would like to see would be an increase of whatever amount of money there might be in your judgment required to meet the needs of all veterans for any conceivable purpose, regardless of what it does to the budget or to the overall problems that this country has with the budget deficits.

I'm a veteran and I understand all of that, and I understand there are priorities that must be set. I'm asking if Mr. Aviles doesn't also feel that priorities have to be set even within the Veterans' Administration and the veterans themselves.

Mr. **Aviles**. I agree that there must be priorities. However, nobody asked me when I went off to war whether—you know, I wasn't an economy figure, and I'm sure these World War II veterans didn't feel that way either when they volunteered their service.

It is unfortunate, as was expressed by Mr. O'Neill earlier, that we have to put a money figure, a dollar sign on this. It's true. I can understand where you're coming from when it comes to dealing with the economy and the deficit and trying to strengthen the programs for veterans in this case. But I just don't understand how we can equate quality health care with cuts in the Veterans' Administration budget.

Mr. **Gekas**. Mr. Aviles, you don't mean to imply that every single veteran, such as I, want my benefits, no matter what it does to the country, no matter what it does to the economy? I'm sure that's not the case and I'm sure Mr. Aviles feels that way.

What we have to do, is it not true, Mr. Aviles, is to do what we can to accommodate the preservation of the economy, which whether you're an economist or not doesn't matter—I'm not an economist. Do you recognize and do I recognize that there's a problem with the budget deficit? Let's say we do, and that the economy, we assume, the health of the economy, rests on our will to do something about that, while at the same time recognizing that priorities must be set in the Veterans' Administration just like every other program, and to do what we can without sacrificing the body and soul of our veterans; isn't that what we're all about to do, and it's not a question of insensitivity, it's a question of trying to do the best job we can under the circumstances?

Mr. **Aviles**. I can agree with you to a certain degree. But if you're going to spend *x* number of dollars for defense, I can't see why you can't spend *x* number of dollars for veterans' programs.

Mr. **Gekas**. Mr. Aviles, do you recognize that every single special interest group that we've met in the last few months says exactly the same thing, and as a result, the original military spending proposals of President Reagan have been cut, then the secondary proposals have been cut, then the tertiary proposals have been cut, and that the final compromise, so to speak, between the Senate Republicans and the White House did a further cut, and that no matter what final resolution be adopted for military spending, there will be an increase, no matter what else happens. Even the lowest possible spending bill for the military will be an increase in military spending.

Recognizing that, do you feel that the answer to your problems is further cuts in military spending?

Mr. **Aviles**. I'm not saying that, sir.

Mr. **Gekas**. That's what I was hoping you would say. Thank you.

Mr. **Edgar**. I think we could save money on the MX missile, but that's my own personal view.

Let me share a quote from someone who is very high up in the administration. "To me, it is unconscionable that veterans in need are denied hospital and medical care because of inadequate funding which has closed hospital beds and cut health personnel within the VA." That's a quote from somebody very high up in the administration. I think that sounds like what you were trying to say, that it was unconscionable that veterans who are in need are denied hospital and medical care.

That quote comes from Ronald Reagan in 1980, when he shared those words before the VA Convention. It was indicated at that point that the President of the United States felt very strongly that we do have a commitment to Vietnam era veterans, Korean era veterans, World War I and World War II era veterans. And yet, 5 years later, we're turning away 20,000 veterans a month from our veterans' facilities, and we have had a series of proposals to respond to the problem of the aging veteran by shrinking the size of the veterans' budget.

I share with my colleague from Pennsylvania the following fact. In 1975, just 10 years ago, for all of the health care needs of veterans, we spent $3.5 billion. And while we project that in 1986 we will spend $9.5 billion for veterans health care, if you adjust those dollars for inflation, in 1986 we will spend $3.2 billion for all of veterans health care. At the same time we have expanded the number of hospitals and nursing homes. We have added 200 readjustment counseling centers for Vietnam era veterans. We have provided additional service to atomic veterans and women veterans and prisoners of war. I think that those of us who have watched the veterans' budget over the last couple of years have, in fact, been very vigilant in trying to target, to restrict, to focus the aid on those veterans who have need.

That's why I still find it very incredible today that we are here at this time, in this committee, trying to figure out whether or not the administration's cost-cutting proposals will, in fact, save real dollars, or whether they will simply shift dollars from the VA to Medicare or to other welfare programs, and whether or not this administration, in shaving the $400 million that they project, will be a savings in 1986, whether or not those dollars will impact on the quality of care given to the neediest of veterans.

Now, already in public law, as of 1980, the Veterans' Administration has the ability to put a means test on veterans benefits for those below the age of 65. All we're dealing with here in the administration's budget proposal is whether or not there should be a means test for those above age 65, the elder veterans, and what the nature and extent of that means test should be, what should be the level, the quality of income that someone is permitted to have and whether or not they have to buy down on their Medicare benefits before they can receive benefits, whether or not in shrinking the eligibility we're really going to impact on the neediest of veterans.

So I still find it very difficult to have on the one hand your testimony, stating that there are real live human beings that we're turning away on a day-to-day basis, and real live human beings that are not eligible and not able to use existing facilities—the State of Florida is an interesting State, where you have this massive influx of veterans and very limited veterans facilities at the State level and at the Federal level and at the contracted level, and whether or not we're going to be able to provide for those veterans.

In the next 5 years, by the year 1990, more than half of all American males over the age of 65 will, in fact, be veterans, will become eligible for programs, and the nature of the way in which we restrict that eligibility is very, very important. Your testimony is helpful to us today in trying to figure out how to respond.

I wonder if any of you, given your grassroots experience, have any suggestions for ways in which the VA might meet the need in terms of low-cost alternatives or regulatory changes that might help you and assist you in doing your job.

Mr. O'Neill. Mr. Chairman, I indicated that excellent presentation by the VA in the "Caring for the Aging Veteran." The VA has proposals in there that that's exactly the way I would react to it in the field. They mention about the additional authority or authority to expand their geriatric research and clinical training. There is also indicated that we don't have a half-way house. I don't know whether that's the best way to express it, but you have no in between where the veteran comes out of the hospital where they can go into an intermediate type care situation, to the nursing home. We're experiencing that in the DRG's which I mentioned in the testimony.

Maybe if the VA was given the authority, grants, seed money, to get more involved with the local community. I serve on a community hospital council in my area. The VA is heavily involved with the community, these community agencies. If they had more authority, I think they could probably develop a better plan into the future.

The Administrator of Veterans' Affairs certainly has made a long-term plan. He's not worrying about budget dollars right now. He has given orders to the VA to make planning. I prescribe to what's in that book, their recommendations by the Veterans' Administration.

Mr. McLeod. Mr. Chairman, in that same regard, I see some alternatives of being of more use by the VA facilities, such as the home health care program, to keep the veterans from having to become casualties of the institution, allowing him to maintain some status in his local community or his local home, preferably, with the VA providing the necessary medical services available to him there.

In addition, one acute problem that has come up, your earlier comments regarding State veterans homes as being a cost-effective means of providing care for veterans is exceptionally true. We in the State of Florida, in our State government, have finally recognized the importance of providing some State level programs for veterans. This past year they have started doing the paperwork necessary to establish a State veterans home in Florida. However, as you are well aware, the VA assigns money for these grants based on a first come/first served type basis. If I remember correctly, our application for funding of a State veterans home in Florida is so far down the list that we may never get to it.

So I think if the committee was to consider the feasibility there of providing some type of priority funding to States which demonstrate an actual need for these additional State facilities to supplement what is being provided by the VA, it would help alleviate some of our short-term problems.

Mr. Edgar. Thank you.

My colleague from Connecticut, Mrs. Johnson.

Mrs. **Johnson**. Thank you very much. I'm sorry that I wasn't able to hear all your testimony. I had to be in and out, but that happens all the time here.

You refer in your testimony to people needing service not being served. In the population under 65 that is service-connected, do you see people not being served because of the means testing requirement in the law?

Mr. **O'Neill**. Ma'am, on the service-connected issue, there's no problem whatsoever there because we don't apply the means test on eligibility——

Mrs. **Johnson**. I'm sorry. I misspoke. I beg your pardon.

Mr. **O'Neill**. But on the non-service-connected cases—You know, some years ago we service officers called it the "pauper's oath." It is an addendum on the application where they make a determination of his assets and his ability to pay. Of course, is one of the factors used in determining his ability to pay. We found no problem. I think it's very adequate.

I am fearful of the new proposals, if we start using a sliding scale of 30,000 or 10,000. It's not necessary. It's going to create a nightmare for the Veterans' Administration administratively. It has already been established that the status quo, the way the VA is operating right now with the means test, is adequate. It does the necessary screening.

I know the chairman mentioned about the 65-year-old veteran. The VFW, of course, we go into a convention and we have mandates and this subject has come up. But personally, individuals over 65 and his ability to pay, I don't see any——

Mrs. **Johnson**. In other words, you wouldn't be uncomfortable with the current system that exists for non-service-connected veterans under 65 to be extended to non-service-connected veterans over 65, without the sort of——

Mr. **O'Neill**. No. I think, in the wisdom of the Congress many, many years ago, when the law was passed, that 65-year-old veterans would be entitled to enter a VA facility without that provision of ability to pay. Of course, the bed availability was still there. That was in relationship to Medicare. It would be cheaper—and some of the figures I reviewed showed 10 to 15 percent delivery of care is cheaper in the VA than in the private sector. So that was just a shift, and that was good. From the taxpayers' point of view, it's cheaper dollars to put them into the VA environment. So it didn't really matter.

Now, if it should come to pass, the veterans 65 and over—most of them, the figures show 90 percent have Medicare when they're over 65—it will be now the veteran would use his Medicare, even though he has ability to pay, and is denied into the VA.

Mrs. **Johnson**. Thank you.

Mr. **Edgar**. Are there any additional questions from any of my colleagues? The gentleman from New Jersey.

Mr. **Smith** of New Jersey. Thank you, Mr. Chairman.

Mr. O'Neill, you have given the committee some graphic information about the dumping of veterans from the community hospitals into the VA system. Does the VA have statistics or case examples nationally on this problem?

Mr. O'Neill. On a national level, Mr. Congressman, I'm not sure. But I do know in our two hospitals that I cited in my testimony, Ann Arbor and Saginaw, I have attached a list. I contacted Ann Arbor and Saginaw medical centers before I came here for the hearing and asked them to give me a list. I don't know how extensive records are kept throughout the system, but I know it is acute in our area and it's very serious.

Where I get fearful—and it is a possibility—you can imagine respiratory care patients utilizing all your ventilatory and cardiac patients, your intensive care units, you could bring the hospital almost to a standstill. It has got to have an impact on the mission—they're going to have to back up. Scheduling surgery could start to get backed up. It's real fearful from that level and this could happen.

Mr. Smith of New Jersey. Do you have any proposals or suggestions that this committee could look into as to how to deal with that, and perhaps the other gentlemen would like to address that.

Mr. O'Neill. I feel that the Medicare regulations, as it relates to the DRG's, should be examined in its relationship to the VA. I'm not unmindful about the medical costs in the country and that something had to be done. I'm not arguing on that point. But I don't want to see the DRG's to have this kind of an impact on the VA. So I feel they should be examined by people in a position who know how to analyze these types of situations, that maybe something could be done.

Mr. Smith of New Jersey. Mr. Aviles, one question for you. There is a very extensive network, as you know, in place under the provisions of the Older Americans Act to help senior citizens get nutrition, home health care, and other assistance.

In your opinion, do veterans take adequate advantage of that network?

Mr. Aviles. No, they really don't. Really, within the VA system, it's up to the social work service to know those programs. Unfortunately, there is a turnover in the Veterans' Administration in the social work service. For example, they might lose a few employees either due to retirement or going into the private sector. The VA would have to hire back at a lower GS rating, for example.

As it was explained to me, a social worker has the responsibility of developing alternative methods for their patients. If you hire a newcomer into the program who doesn't really know what resources are out there, it can be more damaging to the patient client than not knowing at all.

Mr. Smith of New Jersey. How can we help to facilitate that dissemination of information?

Mr. Aviles. Well, within the social work service, as I understand, they would like to see more qualified people on their programs. For example, in the domiciliary section of the Wadsworth or Grantwood facility in Los Angeles, they have 272 residents in their dom. The social workers on their staff are charged with the responsibility of developing these alternatives methods to get them back into the community as productive citizens. Well, they have two social workers for 272 people. We can't understand how they can provide that kind of service when two people are actually doing all this service work.

So they need better staffing and a better staff to go along with that, better quality pay so you can get better quality people.

Mr. SMITH of New Jersey. I have one final question, Mr. Chairman.

Mr. Aviles, you mentioned in your testimony on page 5 that the VA contract nursing home stays for a nonservice-connected disability are limited to 6 months. Do you find many veterans coming up against that 6-month limit and then being discharged, and what happens to them when this occurs?

Mr. AVILES. We run into it more and more as veterans come into the system that are requiring care for nonservice-connected conditions. We get around it by advising the families, for example, to try to get that veteran into the hospital and into the VA system for treatment of an acute condition. If after they're admitted they are deemed stable, they can then be discharged again for an extended 6 months, or you can go directly to the director of a facility and ask for an extension. But that doesn't happen too often.

There are ways to get around it. It's just the people that we deal with will get the service. It is those that don't know where the major problem is going to be felt.

Mr. SMITH of New Jersey. Thank you.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. If there are no further questions, we thank the panel for their statements and we will call our second panel at this time.

Our next panel is Dr. Dallery, Director, Department of Social Services at Bryn Mawr Hospital; Mr. Jon Hunter, Leadership Council of Aging Organizations, Fairmont, WV; and Mr. Barry Jacobson, American Health Care Association, Minnespolis.

While you are getting seated, let me recognize the chairman of the Select Committee on Aging, Mr. Roybal, who has joined us at this point. We welcome you here and are very appreciative of our joint efforts and are pleased that you could join us.

Thank you, gentlemen, for your patience this morning. We will hear first from Dr. Dallery, who will speak first, and then we'll move through the panel. The full text of your statements will be made a part of the record. If you could summarize or abbreviate, where possible, that would be very helpful to the committee. We look forward to hearing your testimony.

STATEMENTS OF CARLETON DALLERY, PH.D., DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, BRYN MAWR HOSPITAL, BRYN MAWR, PA; JON HUNTER, DIRECTOR, AREA AGENCY ON AGING, FAIRMONT, WV, AND TREASURER, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING, ON BEHALF OF THE LEADERSHIP COUNCIL OF AGING ORGANIZATIONS; AND BARRY JACOBSEN, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

STATEMENT OF CARLETON DALLERY

Dr. DALLERY. Mr. Chairman, members of the committee, as director of a hospital social work department, I oversee the placement of our patients in nursing homes. The term "placement" makes it sound like a simple process of expediting. However, the reality is that the process of placing patients from hospital into a nursing home is usually complex, time consuming, emotionally draining, expensive to hospital and family, and sometimes futile.

The burdens of nursing home placement from the acute care hospital do not result from conflicting goals or values. Everyone agrees that no one should go to a nursing home who can be supported in a less restricted and more familiar environment. The troubles arise because of regulatory requirements and procedures that must be met before a person can be admitted to a nursing home with coverage by medical assistance or the Veterans' Administration.

As you know, some areas of our country are experiencing severe shortages of beds for medical assistance patients because reimbursement rates do not meet costs. In those communities, hospitals have to maintain many patients in acute care beds while they wait for lesser level of care beds. Waiting periods of over 1 year are not uncommon.

Sometimes patients who cannot get medical assistance nursing home beds will be taken home by families who have no experience in long-term care of the deteriorating and bedridden person and who consequently find themselves sooner or later exhausted, socially isolated, unable to hope for the patient's improvement, and unwilling to wish for his or her death, which all too frequently is the only way the situation can be relieved. It is fashionable today to say it is better to die at home, but we have to realize there are fewer and fewer households that can be a home in which the dying process can be tolerated.

Let me focus on the situation of the hospitalized veteran needing nursing home care after discharge. As I called social workers of other nearby hospitals to get information for this statement, I was impressed that every single one responded to my request with a kind of choking sound whose meaning was clear enough—getting after care for veterans is an awful process. One worker said it very poignantly: "In so many words, our job is to tell the veteran's family you can't get there from here."

Since most medical episodes are unforeseen, families take patients to their preferred or nearest hospital—usually not a Veterans' Administration hospital. From the acute care hospital, a veteran cannot be admitted directly to a VA nursing home, as the preceding speakers have pointed out. The veteran must be admitted first to the VA acute care hospital. The VA hospital may refuse the patient on sound medical grounds or because of lack of beds.

The paperwork involved in having someone admitted to the VA from a community hospital is extensive, and the approval process typically takes weeks. It is no wonder, then, that hospital social workers are forced to become, as one of them said, "inventive." In other words, instead of the social worker effecting a smooth transfer of the patient from one hospital to the other, the family ends up obliged to take the patient home and provide for their needs there, later getting the patient admitted to the VA hospital. Frequently, I would say typically, major risks have to be run by the family. Whole families must be mobilized and strings must be pulled.

I find it entirely reasonable that a hospital social worker enters into a VA placement case with a feeling of dread. Typically, the worker must start the assessment and application process early, usually at a point where the patient's eventual status is unpredictable, and the patient and family are still hoping for a better outcome, like going home.

Just when patient and family are having to come to grips with the acute episode, they must begin to assemble numerous documents concerning life history, financial resources, military records, and sometimes legal history. So the family who wants to hold on to hope will understandably be antagonistic to the social worker who asks them to begin now talking about nursing home placement.

During this same early phase of planning, the social worker brings the medical evaluation forms to the patient's physician. If the patient's course is still unpredictable, the physician will likely object that it is premature to fill out the lengthy forms. In that event, the social worker must struggle with the physician to get the forms completed and sped on their way to the VA facility.

As the process goes on, the increasingly common final phase is what we in hospitals call the overstay, when a patient remains in the acute hospital waiting for the VA bed to open up. What overstay translates into is that the hospital is not reimbursed for its own costs. During that phase the hospital loses money, the physician becomes vexed, and the family suffers the discomfort of knowing that they should really take the patient home.

I, personally, know of several families who have exhausted themselves exploring alternatives to VA placement, even though they know that nothing else will work. From a psychological point of view, this frantic searching is easy to understand; it's a very, very sad thing to watch.

Let me close with a general remark about the emerging medical assistance system for nursing home care. It is hardly a backup to the gaps in Veterans' Administration services. The processes of application, evaluation and approval have become more time-consuming, have introduced new sources of arbitrariness, and in Pennsylvania, at least, have confronted patients with a formalized interviewing process, by a total stranger, that often is undignified and even insulting to some patients. Again, in the name of diverting people from nursing homes, which everyone would agree is worth doing, another layer of bureaucracy and another tedious chore for patient, family, and social worker has been added.

In conclusion, I offer the observation that our older patients and their families still believe that somehow their needs for medical care and nursing home care will be met. There are, after all, Medicare, medical assistance, and the Veterans' Administration, and promises by administrations of years past. Securing care within any of those systems is more and more frequently like a bad dream, and is sometimes more distressing than the physical problems suffered by the patient.

I would like to be found wrong, but it seems to me that the net amount of misery associated with hospitalization has increased manyfold and for many, many people in the last 4 years.

Thank you.

[The statement of Carleton Dallery appears at p. 99.]

Mr. **Edgar**. Thank you very much for your statement.

Mr. Jon Hunter.

STATEMENT OF JON HUNTER

Mr. HUNTER. I am Jon Hunter, director of the Area Agency on Aging in Fairmont, WV. I am a veteran. I am also treasurer of the National Association of Area Agencies on Aging, which is a member of the leadership council of aging organizations. Today I am speaking on behalf of the leadership council.

The 29 members of the leadership council represent consumers, providers and planners of community-based services for older adults. These services are funded by a variety of Federal, State, local and private resources. However, we all know these resources for these services are quite limited.

In my full testimony I list several examples of local cooperative program initiatives between community-based service systems and the VA. These networks have shared facilities, resources and information, as well as coordinating services with each other's clients.

In my own planning and service area in north-central West Virginia we have developed a formal memorandum of agreement with the Louis Johnson VA Medical Center. This agreement outlines service coordination/case management for veterans and joint training of staff between the VA, the area agency on aging, and the local community-based service providers. A VA staff member also serves on my regional advisory council.

It is important to note the examples listed in my written testimony are not representative of the national picture but, rather, are unique initiatives generally brought about by locally shared common interests in the aging veteran. Unfortunately, in many parts of the country, there are no relationships or joint programming between the VA and the community-based care programs. With the expanding aging and older veteran population, neither the VA nor the aging network have the capacity to handle the increasing demands.

It is our belief that the cornerstone of the development and coordination of community-based and in-home services is title III-B, the most neglected title of the Older Americans Act.

Although our written testimony has cited many examples of coordination between community-based service systems and the VA, we see several policy and administrative barriers which hinder or limit the development and expansion of this cooperation and coordinated planning and service delivery. One is a lack of a national policy regarding the relationship between these systems. Two is the administration budget proposal which will further limit access of needed services for older veterans. Three is a lack of enough flexibility within the VA system to pay for many services offered outside its own system.

Therefore, I would like to suggest the following recommendations as an attempt to begin to overcome these administrative and policy barriers:

First, the VA should further encourage its institutions to develop formal agreements with the local community-based service systems to assure care coordination for individuals and their families. This may be accomplished through agreements with area agencies on aging, a community-wide case management program, or the individual service provider agencies.

Two, the Veterans' Administration must work with its field institutions to encourage the development of payment mechanisms allowing VA funds to be utilized for purchase of service contracts. Older veterans applying for admission or being discharged from VA hospitals may be in need of lower cost community-based services such as adult day care, home-maker chore services, senior transportation, et cetera, which the VA institution may not provide itself.

Three, the Veterans' Administration needs to give special consideration for supporting or developing transportation services for veterans in rural areas needing to access VA or appropriate community services. This critical need again could be addressed through a purchase of service contract with a community senior transportation provider. Again, such an agreement may be mopre cost efficient than institutional care or the VA developing its own transportation system.

Four, the Veterans' Administration should encourage co-location of senior services. For example, an underutilized VA facility could be used for community services serving both veteran and nonveteran seniors. On the other hand, the VA could use a community senior center as an information or service center for veterans living in the community.

Five, the Veterans' Administration should encourage cooperative training of VA and community services staff. Such training should include basic information about each other's service systems. Professionals in both groups are constantly seeking information on such social and health issues as caring for Alzheimer's victims, family support care, et cetera. These training opportunities should also be available to local veterans groups, who may be workers and volunteers within the systems, as well as possible consumers in the future.

These recommendations represent activities that may exist in some communities across the country. However, many of them are impossible to implement without administrative and policy direction from the Veterans' Administration here in Washington, DC. Therefore, the leadership council on aging organizations encourages your serious consideration of these operational recommendations to improve the working relationship between the Veterans' Administration care system and the community-based care systems.

Thank you very much.

[The statement of Jon Hunter appears at p. 101.]

Mr. Edgar. Thank you very much.

We will now hear from Mr. Jacobsen.

STATEMENT OF BARRY JACOBSEN

Mr. Jacobsen. I am Barry Jacobsen, chief operating officer of the Willows Convalescent Centers in Minneapolis, MN. I am pleased to be here to represent the American Health Care Association, the Nation's largest association of long-term care providers, with a membership of over 8,500 facility-based proprietary and nonproprietary providers.

The American Health Care Association appreciates the opportunity to present our views regarding problems and opportunities that result from the interaction of health policies for older veterans and those for the elderly at large.

My principal purpose here today is twofold: First, to discuss community programs currently being utilized by the Veterans' Administration in the provision of health care services to elderly veterans, and second, to suggest other health care service alternatives rendered in the community which the VA might consider using in meeting the long-term health care needs of these individuals.

Before addressing these issues, I want to comment briefly on a related concern being addressed at the hearing today; namely, the impact of the administration's proposed means test on the veteran and on the cost to the Medicare Program.

The skilled nursing facility benefit is a very small component of the Medicare Program. Therefore, it is not likely to be affected by a transfer of veteran patients from the Veterans' Administration to Medicare. The American Health Care Association believes that Medicare's current cumbersome reimbursement and paperwork system and its coverage policies deters long-term health care facilities from participating in the Medicare Program. As a result, many Medicare beneficiaries in need of skilled nursing facility care are unable to receive appropriate care and are backed up in expensive hospitals longer than necessary awaiting skilled nursing facility placement. In our view, if veterans are shifted from the VA to the Medicare system, they may not be able to find available skilled nursing facility beds and, although technically eligible, will not receive their Medicare benefit. Until a prospective reimbursement system for skilled nursing facilities under Medicare is developed, so as to increase the providers available, the availability of community nursing home beds will continue to be limited.

With respect to the VA contract community nursing home program, my written statement contains a complete description of its operational aspects.

We wish to express our belief that the Community Nursing Home Program is a success. Community nursing homes enjoy their involvement with the Veterans' Administration contract program and, conversely, the Veterans' Administration's Office of Extended Care has told AHCA that the Veterans' Administration has been satisfied with the quality of care being provided in community nursing homes and its relationships with those homes. More importantly, veterans placed in these facilities seem to be pleased with the community nursing home placement as well.

In 1983, the Community Nursing Home Program supported an average daily census of 10,212 veterans and supported the treatment of 34,092 total veteran patients. The average per diem cost for contracting services in community nursing homes was $50.68 per day, while costs for providing care in VA nursing homes averaged $93.01 per day.

It is our view that the contract program can and should be expanded. In analyzing the Veterans' Administration's fiscal year 1986 budget, we were disappointed to see that no request was made for expansion of this cost-effective and worthwhile program. However, we were pleased to see the introduction of Congressman

Edgar's bill, H.R. 505, which would facilitate better access to community-based nursing homes.

AHCA believes that increased participation by the VA in the contract nursing home program may be expanded through negotiation of reimbursement rates with payment made according to special patient care requirements. In this way, patients requiring highly specialized heavy care would carry a higher reimbursement than those needing lesser care. In addition, there could be a special reimbursement system for provider services for veterans requiring an exceptionally high level of care when the costs exceed current statutory limits.

For example, a community nursing home might develop special units to care for veterans with more acute needs, such as the spinal cord injured or someone who is respirator dependent. Such an arrangement would necessitate a reimbursement rate which would reasonably compensate a facility for the costs associated with the special care required for those patients.

Two additional recommendations for the expansion of the contract community nursing home program include extending the annual renewal requirement to allow for more accurate long-range planning, and contracting by a VA medical center for a specific number of beds in a community facility to assure availability when that availability is required.

Several weeks ago the American Health Care Association testified before the House Veterans' Affairs Committee Health and Hospital Subcommittee regarding the Veterans' Administration health facility construction. In our testimony we provided the subcommittee with recommendations regarding private construction of nursing homes which the VA could lease for its use, or the leasing by the VA of existing private nursing home, or floor or wing of such a facility.

Since that hearing, further discussions of these proposals have been held by the American Health Care Association with House Veterans' Affairs Committee staff. The results of those meetings disclose a need for cost data which would compare building specifications of an existing Veterans' Administration nursing home facility with that of a community facility. We intend to pursue this information and will be happy to provide it to the two committees as soon as it becomes available.

In summary, the American Health Care Association believes that to help meet anticipated needs for caring for the elderly veteran, the Veterans' Administration should increase its utilization of community nursing homes as well as consider other alternative arrangements for provision of needed services. The VA's mission to care for the nation's elderly veterans is not unlike that of American Health Care Association's member facilities. We believe that working in concert with the VA to provide health care services more cost effectively, while maintaining quality care for the patients, can be accomplished.

We would like the opportunity to develop programs which could explore new ideas to do this.

I would be happy to respond to any questions.

[The statement of Barry Jacobsen appears at p. 104.]

Mr. EDGAR. Thank you.

I yield to the chairman of the Select Committee on Aging, Mr. Roybal.

Mr. ROYBAL. Thank you, Mr. Chairman. I wish to first of all compliment you for holding this very important meeting on a most important subject.

Just this morning, as the chairman of the Subcommittee on the Treasury of the Appropriations Committee, we had before that committee Mr. Stockman, who as you know is the one gentleman that has jurisdiction over all budgets. We were able to place in the record the fact that he has also oversight capability and that he reviews testimony that is presented to congressional committees by anyone in any department. After OMB reviews that testimony, it is then returned to the committee for final printing.

This clearly indicates to me one way that OMB controls every statement that is made to a committee by anyone in any department of the Federal Government. We are looking very closely into this because of its affect on all departments of the Federal Government, particularly when the recommendations that are made reduce vital programs. Reductions have been made or recommended in health, in research, in the Veterans' Administration, in all those things that service the public.

I had the opportunity to just briefly discuss with Mr. Stockman another issue of importance to veterans, and that is the so-called means test that is now being studied by the White House. I handed him a letter, asking him to explain what the White House plans to do about that means test, and what it means, what effect will it have on veterans. At this point, I wish to insert a copy of this letter for the record.

[NOTE.—The letter referred to was delivered personally to Mr. Stockman by Chairman Roybal prior to an appropriations subcommittee hearing on OMB's budget the same morning as the hearing on older veterans.]

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC, April 23, 1985.

DAVID A. STOCKMAN,
Director, Office of Management and Budget,
Washington, D.C.

DEAR MR. STOCKMAN: A joint hearing is being held today by the House Select Committee on Aging, which I chair, and the Veterans Affairs Subcommittee on Hospitals and Health Care regard older veterans. In light of the Department of Health and Human Services' decision not to honor the Committees' request to present testimony at the hearing, I am concerned that the Administration is not adequately addressing intergovernmental concerns with respect to our aging veteran population. I also am asking that the Office of Management and Budget respond to questions concerning the proposed means test for veterans. Copies of correspondence relevant to the hearing are attached.

The purpose of today's hearing is to review the impact studies of the proposed VA means test that our Committees requested of both the Department of Health and Human Services and the Veterans Administration. It is also to examine the broader question of how agencies are preparing to serve increasing numbers of older veterans.

As indicated in Mr. Edgar's and my response to Secretary Heckler on April 19, 1985, we view the needs of increasing numbers of older veterans as an intergovernmental responsibility. I agree that the Administrator of the Veterans Administration is the appropriate spokesperson for the Administration on veterans policies. However, the fact that 85% of all U.S. veterans will never be seen by the Veterans Administration, that veterans and their spouses are directly affected by programs of both the Veterans Administration and the Department of Health and Human Services, and that the policies of these agencies interact in a way that impacts the beneficiaries of both, makes the issue of growing numbers of older veterans not only one of national scope, but of inter-agency jurisdiction as well.

As Director of the oversight agency for intergovernmental issue, what actions are being taken by the Office of Management and Budget to encourage a more active dialogue between the Department of Health and Human Services and the Veterans Administration on matters of concern to growing numbers of elderly veterans and non-veterans alike?

Regarding the Administration's proposed VA means test for veterans, it is my understanding that the White House is conducting an internal study of this proposal in conjunction with the Veterans Administration. Yet, the President's original budget and the Republican Leadership Budget Package indicate that a means test would be implemented during FY86.

Given the significant impact the means test will have on the out-of-pocket costs of veterans and their access to care, should not a decision on the implementation of a means test be delayed until results of the Administration's study are known? I would appreciate receiving information on the scope, lead agency, and time frame of the Administration's study, as well as a copy of the study results once completed.

Thank you in advance for your cooperation.

Sincerely,

EDWARD R. ROYBAL,
Chairman, Select Committee on Aging.

Mr. ROYBAL. You gentlemen that have testified this morning no doubt have a pretty good answer to that question on impact that I asked of Mr. Stockman. It will have a tremendous effect. But I am not going to ask you. I will wait until Mr. Stockman responds, and then perhaps get more information from you later. But there are other questions I would like to ask you at this time.

Mr. Dallery, you mentioned that pre-admission Medicare and VA requirements are significant barriers in trying to arrange nursing home and in-home care for patients. What are these barriers and which of these barriers pose the biggest problem?

Dr. DALLERY. The major barrier to having a veteran admitted to a nursing home is simply that the veteran has to be an inpatient in a Veterans' Administration hospital first and has to be accepted by that hospital for admission. There are different criteria that would apply in making that acceptance, and there are complicated processes to go through—committee reviews and so on. The delays that I am familiar with myself have had to do more with the committee processes in approving admission than with any barriers.

I'm not sure that answers your question.

Mr. ROYBAL. I think it does, partially. But it still doesn't answer my greatest concern, and that is you also made reference to the fact that the elderly and their families face increased problems and that these problems had increased several fold over the past 4 years.

Will you elaborate on this? Perhaps we can get the full response to both questions as you go along.

Dr. DALLERY. Let me just make one very general observation about the health care environment at this time.

Since the inception of DRG's, which I will have to assume everyone is familiar with, the mood of anxiety surrounding any hospital admission is significantly higher on the part of everyone. To some extent, that anxiety may be due to not understanding something new. Physicians are more anxious, families are more anxious. We encounter families whose initial presentation to us is "we came to see you about getting our patient kicked out of the hospital." So that is one initial opening shot in the hospitalization experience.

The criteria for accepting a patient in a nursing home or for home health care have been applied more stringently in recent years. We expect that they are going to be more stringent in their design and not just their application.

Ancillary resources in the communities have been reduced significantly in the past 4 years, not so much for the elderly citizens but for others who happen to be in families who do have elderly citizens.

Mr. **Roybal**. Let us review just very briefly this whole situation. Your remarks indicated that the misery faced by the elderly and their families has increased several fold over the past 4 years. To what extent has it increased, in your opinion? Has it doubled; has it tripled?

Dr. **Dallery**. I would say it's doubled. We have people who are working from a much tighter family budget, also, and that is a part of it.

Mr. **Roybal**. Now, Mr. Hunter, given the increasing numbers of veterans—some 80 percent of whom will never see the VA—added to the pressures to scale down the VA system, will community providers be able to absorb greater demand for services? Will older veterans, as well as nonveterans, have access to the care that they need?

Mr. **Hunter**. In my opinion, we are already seeing a major impact of those factors. We are having increasing difficulty in meeting those demands with our limited resources. I don't see how, unless there is some shifting of resources or reorganizing of the programs, or something done about some of the barriers that I talked about earlier, I don't see how we can meet those demands.

I can tell you, for example, our referral system from hospitals, the area agency that I'm in charge of, has more than doubled in the last couple of years. The number of home-delivered meals that we provided last year alone increased by 10,000 meals. It went from 68,000 to 78,000 home-delivered meals in one year, without any increased resources.

Mr. **Roybal**. The way I understand it, then, both you and Mr. Dallery agree that the problem has increased, it is more acute than it was before, maybe even doubled or more than that. We know that the recommendations that we get from the administration to this increased need is that the budget be reduced. We can only conclude that services to veterans, particularly the elderly veteran, is definitely being restricted; is that correct?

Mr. **Hunter**. I would agree with that.

I am also a member of my local VFW, and I know one of the most common conversations is on veterans' benefits when I attend the VFW. One of the greatest fears of many of my veteran colleagues is the fear that they had assumed that their medical needs and long-term care needs would be taken care of when they became elderly, and now they are very fearful that that will not happen.

They had also assumed that when they became age 65 and were on fixed incomes they would have a quality of life that would ensure that they could continue to enjoy those later years of life.

Now many of them are seeing their friends and colleagues go from being on fixed incomes and being able to meet their needs, but because of health care costs and such, are being forced into poverty and on the Medicaid Program. That is one of their biggest fears, being forced from a nonpoverty status into a poverty status.

Mr. ROYBAL. Thank you, Mr. Hunter.

I remember that upon discharge from the U.S. Army we were told what great benefits we would be getting from the Veterans' Administration. Promises were made then that, in my opinion, are not being kept today.

I would like to ask Mr. Jacobsen a question with regard to his statement—and this will be the last question, Mr. Chairman. I realize that we are on a time limit.

What are the most significant barriers that prevent or discourage community nursing homes and other long-term care providers from working more with the Veterans' Administration? How can these barriers be eliminated, if there are any, and then perhaps you can tell this committee if legislation will solve the problem?

Mr. JACOBSEN. I think that the major barriers probably exist in the limitations of numbers of contracts that can be let in any given area. I think providers, at least in our area, and I think in a wide area around our State of Minnesota, are ready and willing and in the past have had a very good relationship with the Veterans' Administration in working with community-based contracts arrangements and are willing to expand that to a wider number and wider variety of both facilities and services. I think in the past few years, in the past 5 years in particular, health care providers have been diversifying and offering a much wider variety of types of service and a wider menu, if you will, of available products for clients.

I think there is a large cost saving available there in the Veterans' Administration utilizing those to a higher degree. I think also there is an increase in the quality of alternatives that are given to that veteran who is waiting to get into another facility and unable to do so.

Does that answer your question, sir?

Mr. ROYBAL. Yes, sir. Thank you.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

I just want to remind my colleagues, as I yield to them for questions, that we do have two additional panels this morning, and this afternoon, and this evening [laughter]. So I would hope that we could be brief in our questioning of the panels.

Let me yield to my colleague, Mr. Smith, and then to my chairman, and then we'll yield to others.

Mr. SMITH of New Jersey. Thank you, Mr. Chairman.

In light of your statement, I will only ask two of the five or six questions I had intended.

Mr. EDGAR. All questions will be submitted for the record.

Mr. SMITH of New Jersey. Mr. Jacobsen, as you probably know, surveys conducted by the Intergovernmental Health Policy Project and the National Governors Association in 1981 found that more than 40 States took action resulting in reductions in benefits, eligibility, provider reimbursement, and/or limiting the construction of new nursing homes. This is very disturbing, to say the least, in light of the growing demand.

Can you give some additional information on specific actions of these several States, and have any States been expanding their nursing homes?

Mr. **Jacobsen**. I will try to answer within the realm of my expertise. I do not have total knowledge of all States, obviously.

I think that on the first part of your question, the restrictions that have been placed on the expansion of the long-term care system, the bricks and mortar part of that system, have included such things as rate caps, moratoriums which have been placed on the system in a number of States around the country, as well as a severe restriction on the certificate-of-need process. However, there are States that are still vigorously building nursing home beds and still allow for that building to go on.

Mr. **Smith** of New Jersey. Does the American Health Care Association have those statistics on which States are——

Mr. **Jacobsen**. Yes, we can furnish that for you in written form.[1]

Mr. **Smith** of New Jersey. We would appreciate that.

Mr. Hunter, if you could answer one question. Private health insurance covers, it is my understanding, only about 1 percent of the total expenditures for nursing home care. What do you think the outlook is for insurance companies offering private long-term care insurance in the future, and do you have any information concerning the possibility of a geriatric expanded private insurance program to pay the cost of nursing care in the private facilities, home care and private nursing home beds?

Mr. **Hunter**. As you know, there is almost no insurance of that type being offered at this time. I do understand that the American Association of Retired Persons is about to come out with a long-term care insurance policy. I'm not familiar with the details of that policy and am not quite sure exactly when it's going to be released, but I think it's very shortly. I understand a couple of other insurance companies are looking into that.

I did attend a workshop not too long ago on long-term care health insurance, and most of the insurance industry representatives said that they did not see how this was ever going to be a solution to that problem, that it was too expensive an insurance policy. All they could see was that it would be a supplement, similar to a medigap insurance policy.

Mr. **Smith** of New Jersey. One final question to Dr. Dallery.

If Congress amends the law to permit direct admission to contract nursing homes from private hospitals, or from the patient's home, what do you foresee as the additional cost to the VA?

Dr. **Dallery**. As the additional cost to the VA.

Mr. **Smith** of New Jersey. As I think you know, we only provide some 10,000 contract beds.

Dr. **Dallery**. Yes. That's a very interesting question and I regret to say I can't imagine what the additional cost would be. The system, from my point of view, would work better for the people in need.

---

[1] See p. 107.

Mr. **Smith** of New Jersey. Perhaps the VA witness could provide that later on in the hearing.

Thank you.

Mr. **Edgar**. Thank you.

We are very honored to have the chairman of the full House Veterans' Affairs Committee here with us today, Mr. Montgomery. I will yield to him at this time.

Mr. **Montgomery**. Thank you, Mr. Chairman, and thank you for having this important meeting. I would certainly like to welcome Chairman Roybal and Miss Schneider, who are members of the Select Committee on Aging. I think this is a historic occasion in that these two committees could get together and talk about the aged, especially the aged veteran.

To our members of this other committee, we do place a priority on medical care for veterans, in that we don't consider it a major problem on taking care of the elderly, but we think it is a challenge and with your help and others on this subcommittee, you are right on top of it.

There will be some things that we can't do, but I feel pretty comfortable that as these veterans get in their twilight years we are going to make their lives more comfortable. We might have to move to more outpatient clinic care and let them go home at night and sleep in their own beds. They like that, the veterans I have talked to. And we might have to move to more nursing homes, especially State nursing homes. I am pleased to say the Mississippi Legislature authorized a State veterans nursing home. The State will run it but the Federal Government will help. It will mean some veterans will live longer and in more comfort by having these nursing homes available.

To Chairman Roybal, we have already had that problem of Mr. Stockman reviewing testimony from any Government officials who come up before this committee. I have written him a letter and would be glad to give you a copy of that letter. In fact, we have gone public with it. It is just not right, after a witness has testified, or even before he testifies, a witness from the Government or from the Veterans' Administration, to have his testimony reviewed and, in effect, told what he must say. We hope this will be corrected. We are sorry that this has happened.

Thank you, Mr. Chairman. I think a lot will come out of these hearings.

Mr. **Edgar**. Thank you very much.

Mrs. Schneider.

Mrs. **Schneider**. Thank you very much.

Mr. Jacobson, in reviewing some of your testimony you mentioned some of the possible cost saving proposals that the VA might be able to implement and your association had made these recommendations before the Veterans' Affairs Hospitals and Health Care Subcommittee here.

I am wondering to what degree you have defined both the short- and the long-term costs. Have you done a cost-benefit analysis on those recommendations?

Mr. **Jacobson**. AHCA is currently preparing an analysis on new construction of buildings, both done by the Veterans' Administration and done in the private sector. Beyond that, we can submit written testimony on any information we have in that area.

I believe, as I stated in terms of the daily rates, that the cost effectiveness of using community providers can be shown. By looking at the average rate expended for long-term care in the community, versus that charged in the Veterans' Administration facility, I believe there is a large group of clients that can be handled under that community-based program and, as a result, would be a savings to the Veterans' Administration.

Mrs. SCHNEIDER. But do you have any hard figures on the leasing, for example, of private homes?

Mr. JACOBSON. No, I do not. That is being prepared and we will submit it in written testimony.[1]

Mrs. SCHNEIDER. OK. That would be great. We would appreciate it.

I have no further questions, Mr. Chairman.

Mr. EDGAR. Thank you.

Mrs. Johnson?

Mrs. JOHNSON. I have no further questions, Mr. Chairman.

Mr. EDGAR. Mr. Ridge.

Mr. RIDGE. Thank you, Mr. Chairman. I apologize to you and to the witnesses for being a little late. I have no questions but I would like to reserve the right to submit questions in writing once I have had an opportunity to review the testimony.

Mr. EDGAR. Without objection.

Mr. RIDGE. Thank you.

Mr. EDGAR. I have a number of questions that I will submit for the record. There is one I would like to address to Mr. Dallery.

You referred in your statement to the term "medical assistance." I am not sure that that term is consistent with all States. Maybe you could just describe that term for us.

Dr. DALLERY. The medical assistance program in Pennsylvania, called the Medicaid Program, is the federally supported but State-administered fund for the people who meet the eligibility requirements of family income.

Mr. EDGAR. One of the things that the service organizations as they testified before us—the American Legion, the VFW, all of the major service groups—have been concerned about is the shifting of VA services to the Welfare Program, to medical assistance and to other social programs. One concern that I have with the policy decision in terms of a means test for those over age 65, and some of the third-party reimbursement decisions, is whether or not there will be a shifting even further to medical assistance and to welfare for some of these veterans who are already struggling for basic services.

I appreciate the testimony of all three of you. I know you will receive some questions for the record, but we appreciate your taking the time to be with us today.

Mr. EDGAR. Our next panel will be Dr. Donald Custis, Director of Medical Services for the Paralyzed Veterans of America, and former Chief Medical Director of the VA, and Dr. John Rowe, who is the director, Division on Aging, Harvard Medical School, and Director, VA Geriatric Research education Clinical Center in West Roxbury/Brockton, MA.

---

[1] See p. 109.

I understand that Dr. Rowe has an airplane that he needs to catch. I have been advised that we don't have the power to hold that airplane. So I wonder if it might be wise for you to begin and for us to address some questions to you, and then we will move to Dr. Custis.

STATEMENTS OF JOHN W. ROWE, M.D., DIRECTOR, DIVISION ON AGING, HARVARD MEDICAL SCHOOL, DEPUTY DIRECTOR, DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION, HARVARD UNIVERSITY, AND DIRECTOR, VA GERIATRIC RESEARCH EDUCATION CLINICAL CENTER; AND DONALD L. CUSTIS, M.D., DIRECTOR OF MEDICAL SERVICES, PARALYZED VETERANS OF AMERICA, AND FORMER CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

STATEMENT OF JOHN W. ROWE

Dr. Rowe. Thank you, Mr. Chairman. I think you are being modest as to what power you have over the airlines, but we will proceed. [Laughter.]

I am a physician interested in health care for the elderly and in health policy. As mentioned, I serve as director of the Division on Aging at Harvard Medical School and as Director of the Boston area GRECC of the VA.

This morning I would like to make two major points. First is that there is, in my view, an urgent need for coordination, integration, and sharing of VA and non-VA geriatric health resources. As the costs of health care increase and the Federal agencies attempt to limit their expenditure, older veterans are clearly at risk of becoming the "boat people" of the health care system.

Second, suggestions in recent reform proposals that the role of the VA as a provider of health care should be restricted or eliminated are particularly short-sighted when it comes to geriatric medicine.

As far as the need for integration and sharing, let me briefly review several points. As we all know, the number of older veterans is increasing very rapidly. Previously unimagined numbers of veterans are going to be very, very old, and many of these have dual eligibility. Presently all veterans over age 65 are currently eligible for VA health care, and 81 percent of these also qualify for Medicare, 4 percent for Medicaid.

Our studies indicate the presence of a complex interaction between the VA and the non-VA health care system with regard to the elderly veteran. Changes in one portion of the health care system will have a dramatic effect on other portions. Increasing costs for patients in one sector will naturally drive patients with dual eligibility to the less restrictive or less expensive option. For instance, we project, that if further increases in Medicare B cause only 10 percent of elderly veterans currently using the non-VA health care system to give up their private physician as a source of care and turn to the VA, the VA can anticipate an increase of roughly 15,000 veterans seeking hospitalization and 40,000 requesting outpatient care.

There is substantial geographic variability in both the VA and non-VA components of care. This is relevant to the questions asked earlier about the impact of delivering all of these veterans into the non-VA sector. The answer is the impact is very different, depending on the geographic area. Between States there is a fivefold difference in the availability of nursing home beds. There is also a dramatic difference in the availability of home-based or community-based programs. If you were to close down the VA health care system, in some areas the veterans could be absorbed and in other areas you would create chaos, particularly in Florida.

The second major point I wanted to stress relates to recent reform proposals suggesting that the VA medical health care system be replaced, wholly or partially, with a system of publicly financed insurance for veterans. As a geriatrician with some experience in health care delivery, I find this just unbelievable. First, it is widely recognized that the VA has taken a leadership role in the development of geriatrics in this country. The well developed and widely recognized GRECC Program, the extensive training programs that currently train more geriatricians than any place else in the United States, and the recent studies on geriatric assessment units show that they were effective, followed by the swift development of these throughout the VA, are just three examples of what the VA has done in geriatrics. It is unthinkable what the impact on American geriatrics would be to close this section.

Second, the VA has substantial advantages in the care of the elderly veteran since it is a centrally administered, vertically integrated system including multiple levels of care. Old patients frequently move from nursing homes to acute care hospitals and back to nursing homes. That is the nature of illness in old age and were those patients in the non-VA system they would be moving between agencies often with long delays.

Third, as I mentioned before, there is regional variability and the system could just not handle closing the VA long-term care facilities in some areas.

In view of those considerations, I think we should move forward with a strategy of sharing of VA and non-VA health resources in this area.

Thank you very much.

[The statement of John Rowe appears at p. 113.]

Mr. EDGAR. Thank you very much for your statement.

Let me yield to Mr. Royal at this time for questions.

Mr. ROYBAL. Dr. Rowe, there is one question in particular that I would like to ask you at this time, and that is in regard to encouraging cooperation.

How could we ensure that by encouraging cooperation between the VA and community providers we do not end up pitting veterans against nonveterans and in that way even jeopardizing access to health care for both groups?

Dr. ROWE. I saw that as well and noted it with interest. I think it shows a tremendous amount of insight into the potential process here.

I think it is clear that veterans are going to have to have access to VA health care and non-VA health care, and I think it is clear that nonveterans will have to have access to non-VA health care primarily. So the issue of pitting one against the other is going to come in the relationship of the vet versus the nonvet in the non-NA component. It seems to me that the issue there is going to have to be related to equivalent cost or payments in kind and the availability of some sharing of VA resources for some non-VA. It can't all be a one-way street. It can't just be that the community gives to the VA. I think there are special cases, such as spinal cord injury, where the VA has tremendous resources and expertise and they have to be willing to do some sharing and trading off.

But I am confident that the system can be developed if there is equity in the payments without individually pitting the veteran against the nonveteran and giving one an advantage to resources.

Mr. **Roybal**. One matter that is also troublesome is the fact that the veterans that are 65 years of age and over, under recent proposals, will be subject to a means test. How is this going to add to the problem of access?

Dr. **Rowe**. Well, I think that it will increase the number of boat people, if you will, in terms of those veterans who may not be eligible for Medicaid—because if they were, they would be included certainly in the VA program—but who compensation for long term care will break them or their families financially, and there are a lot of people in that boat. Those people are now out in the community, going broke, spending down, in long term care facilities, and if they have access to the VA, if they qualify, that saves them. It is going to increase the number of people who have that problem because they're not going to have access to the VA. They are the boat people. After 6 months, for instance, in the long term care facility, which the VA is not going to pay any longer, they will be in trouble. It's very clear.

Mr. **Roybal**. Thank you, Doctor.

Mr. **Edgar**. Thank you.

Mr. Smith.

Mr. **Smith** of New Jersey. Thank you, Mr. Chairman.

Dr. Rowe, in reading your testimony, I notice you make the point, As costs of health care increase and Federal agencies attempt to limit their expenditures, older veterans are at risk of becoming the boat people of the health care system unless agencies coordinate their programs.

Could you expand upon this concept of the aging veterans becoming the boat people?

Dr. **Rowe**. Yes. I think that if we accept the fact that agencies behave in a manner to protect their own interest, turf and budget, and that most agencies are not currently looking to expand their influence by expanding their budget, that what is going to happen is that the VA will try to save itself, obviously, being underfunded, and will increase restrictions on veterans, such as a means test. It's perfectly reasonable. I mean, the general availability of health care to all veterans over 65, independent of other things, seems out of date, doesn't it.

But if you are going to do that, then that is going to drive people to Medicare/Medicaid. Then the non-VA system gears down a little bit to try to save money and they get driven back to the VA and back and forth. This is what I mean. That unless there is some coordination, you tighten Medicare part B and you had better have somebody up all night opening the door to the VA hospital because they're going to flock in. The VA is very vulnerable because their market share is so small. It's about 15 percent. So a small change in the non-VA component is going to overwhelm the VA system.

The VA's only response can be to tighten eligibility to keep itself above water, and those people are going to be left in the middle. That's really what I mean.

I can give specific examples—we don't have time here—but I have some vignettes of patients that I have seen in the last month who fall in between the cracks, real patients, and one with 31 years of service in the Marines. But he wasn't injured during a war, during a conflict, and didn't qualify for this or that and fell through the cracks as things get tightened up.

Mr. **Smith** of New Jersey. Thank you, Doctor.

One additional question. What role do you see the academic community continuing to play in assisting the VA to meet the challenge presented by the aging veteran population?

Dr. **Rowe**. Well, I think I can be very specific there. Because the Veterans' Administration has developed these GRECC's, which represent a substantial portion of the total academic geriatric resources in this country, there are close links with medical schools, such as the one that I'm at, Harvard Medical School.

What we are able to do in our facility is increase the quality of geriatric care. We are a resource for teaching doctors and nurses about the special problems of the elderly. We make it a more attractive place for health providers to work because there is more education and research. So I think that for a very small investment the VA has co-opted the system in geriatrics, and that's where the action is in academic geriatrics right now, in the VA.

Mr. **Smith** of New Jersey. Thank you. I commend you on your outstanding work.

Dr. **Rowe**. Thank you.

Mr. **Edgar**. Mrs. Johnson.

Mrs. **Johnson**. You mentioned the multiple levels of care and that that's one of the strengths of the VA system, that sort of vertical flexibility. That hasn't been my experience. And while you do mention there is great variation throughout the States in terms of the nature of the system, what do you see as the solution, as the veterans population ages, to the need for more intermediate care, for more home care? Do you see as a more useful direction more fee-for-service and, if so, do you think the VA system should be sending acute care out for fee-for-service and retaining different kinds of care where there is greater need for this vertical movement from one institution to another?

I mean, should we look to become a health care system that is particularly focused on the needs of the elderly, where there is need for changes in levels of care frequently, home care services and all those things, and concentrate on creating that continuity of care for certain kinds of illnesses, rather than on providing both acute care and the varieties of care that are required by aging and prolonged disease?

Dr. **Rowe.** OK. Well, that's a broad question, Mrs. Johnson. In terms of my view as a solution, I can give you some specifics in trying to address this issue.

The more broad description of my view of the solution is in this 500-page book which we just published on linking the VA with community resources in the care of the elderly, but I will spare the committee, in the interest of the commercial airline schedules, great portions of that.

I did want to correct one assumption which I think is in much of the testimony here—in fact, in much of what the VA leadership itself does when they think about geriatrics. When we're talking about geriatrics, we are not talking about long-term care. There has been a preoccupation with that. Forty-five percent of the health care of older people is acute care. Older people have more acute illnesses. When they have chronic illness and they're in a long-term care facility, that gets punctuated by acute illnesses that require acute care. So the value of the VA, you see, is that it has acute care with expertise in geriatrics more than in the community, and long-term care.

If you just had a long-term care system for the VA, and you had the acute care in the community, you would have the patients bouncing back and forth and back and forth. It doesn't make any sense. Those chronically ill patients need operations, they have heart attacks, et cetera, and they are five times more likely than their younger counterparts for acute hospitalization.

I also serve as chief of geriatrics at the Beth Israel Hospital in Boston, which is an academic hospital of some note. The average age on the inpatient wards at that hospital is 73. So it is important for you to understand in health that geriatrics is not just long-term care. It is lots of everything, long-term care and acute care. Because of that, you need a system where you have both components under one roof, if you will.

Does that address your question, Mrs. Johnson?

Mrs. **Johnson.** I think the point you make is a very interesting one and a very valid one. I, frankly, didn't have any idea that the statistics were so high, although I do run into that more in my private hospital sector than I do from my contact with my veterans.

But in developing intermediate care and home care capability, I guess then the question I would ask as a follow on is, should that be developed and expanded within the system or without?

Dr. **Rowe.** I think both, but it depends on the regional variability. You see, if you're in a State like Massachusetts that has excellent home care programs, the VA should have increased access to contract for those home care programs. If you're in a State where the VA, in fact, represents the resources, and there aren't those in the community, it is more difficult.

In general, I think the VA should contract much more to the community. I'm not looking to put it all under the VA's roof. I am looking for increased access on the part of the VA.

But as we have heard in prior testimony, there is now no formal mandate for agencies to plan together, to include the VA when they plan. So there is regional health care planning for a State without any input from the VA.

I see the major portion of the solution to be increasing access of the VA to community resources in some sort of sharing manner, as a one-sentence response.

Mr. EDGAR. Any additional questions?

Mr. Ridge.

Mr. RIDGE. Thank you, Mr. Chairman.

Doctor, first of all I want to thank you for your statement, with particular reference to dual eligibility of many of these veterans. It is clearly a situation that, either way, the Federal Government will be involved in providing treatment and by posturing the VA, and the reduction of services being a cost-saving measure seems somewhat illusory based on the statistics that you have presented to us.

You mentioned that a modest increase in Medicare part B you would project would cause only 10 percent of all older veterans to leave local physicians as a source of care and come into the VA system. Based on your studies, would you care to comment on whether or not that modest shift in the premium and the attendant pressure on the system for treatment could be met by the VA system, as you see it?

Dr. ROWE. That's an excellent question. Again—and I have to keep coming back to this; it sounds like I'm jumping out of the noose, but I am not. It could be met in some areas but not in others. There is tremendous variability. You can say the VA is the giant of geriatrics, but there are only 10 GRECC's and only 49 hospital-based home care programs. But there are 172 medical centers. So 123 of the medical centers don't even have a hospital-based home care program yet.

So, depending upon which particular area you picked, it would be all right, or it would be chaos. Anybody who looks at that variability should say, "Well, why don't we have these two groups plan together so we can improve this?"

So my general answer to you is, "No"; the VA could not handle it at all. Some VA medical centers might be able to handle it. But in general, it would far exceed the capacity of the VA to handle it.

Mr. RIDGE. A little bit further on in your testimony, you said that you believed congressional action was needed to stimulate the VA and other Federal agencies to coordinate and to share resources for the benefit of older veterans.

Given your time constraints with the airline schedules and our inability to review the 500-page book, do you have any specific public policy recommendations that you might want to share with us, or do you recommend that we just read your treatise?

Dr. ROWE. No, no, I wouldn't recommend you read the treatise.

Yes, we have listed about 18 very specific options that the VA should get involved with, and I will mention a couple to give you flavor of the kinds of things that we should do.

We think it has to be a two-way street. We think that the VA should get increased access to community services by establishing a community coordinating office. Right now there are social workers in the non-VA that don't know anything about the VA. It's like a foreign language to them. And there are people in the VA who don't know anything about outside. We think the VA should establish community coordinating offices to find out what's out there, and then establish a case management program with access to both resources.

We think the VA should take care of the families of veterans in some way, providing them more help at home to take care of the older veteran, giving them either financial support or other support, because it is well known that you can keep people at home longer if they have family supports. But currently it is hard for the VA to give something to a family member rather than to the veteran.

We think that the VA should be involved in central planning. It seems reasonable.

What should the VA give up? It should give up some resources in spinal cord, for instance, and other special areas, in which it has the lead in the GRECC's. The VA should educate people in geriatrics from medical schools and other hospitals in some way for return for access to the health care there. So those are a couple of specifics.

They could contract for more transportation, as we have heard, make better contracts for nursing home beds, et cetera. We have a series of specific options.

Mr. RIDGE. Well, I plan on reviewing them. I thank you for your testimony.

Dr. ROWE. Thank you.

Mrs. JOHNSON. Will the gentleman yield for a moment?

Mr. EDGAR. I yield to Mrs. Johnson.

Mrs. JOHNSON. Just one brief comment.

I very much appreciate your testimony in regard to access to community-based programs, but I would point out that at least one of the things that I really was confronted within the last district work period, when I spent a lot of time 10 days ago at my small hospitals and at my VNA's, was that what is happening out there is that as DRG's get in place in the private sector—and this was bound to happen—as they get in place in the VA system, then they are putting people out in the community who are more frail, more sick, and who need more care. But those agencies whose responsibility it is to care for those people are being impacted by the general concern about health care costs in our society.

At least in the cases that I am able to document, the Federal law has not changed. It is not the Reagan administration that is the boogieman. The regulations have not changed. But the fiscal intermediary is redefining what is chronic care, what is intermittent care and so on, in spite of Federal laws and regulations. This whole thing of continuity of care in relationship between home care and institutional care, so important to people and so important to quality care and also cost, is going to be extremely difficult because of the enormous pressure that we have been a part of in building up for cost control without regard to either quality or access.

So I hope that as you work in this area you will help us work out some of those problems of definition that are the difference between availability of care and nonavailability of care, even if the services are there and even if we write the contracts.

Thank you.

Dr. ROWE. Mrs. Johnson, I think you know at least as much about this as I, from listening to your comments, and I think we have defined the problem. That's where we are at this point. The question is not whether or when the VA should get together with the community, but how. We need your help to do that, because you can exert influence on the agencies and the VA can't.

Mr. **Edgar**. Dr. Rowe, I want to thank you for briefing our committee when we did have an opportunity to go to Massachusetts and tour the geriatrics research center. We do have some legislation where we want to try to expand that program and try to reach out to a few more of our health care facilities.

In light of the fact that you have written quite extensively on the older veteran and linking the VA with community resources, it would be helpful to us, in answer to Mr. Ridge's question, if you could pull out of that document the 18 or so specific recommendations that you make and we will submit that for the record here, so that we can be clear in analyzing those recommendations.

Dr. **Rowe**. I would be happy to. I want to emphasize that those would be recommendations of Harvard University and not the Veterans' Administration.

Mr. **Edgar**. I appreciate that. The disclaimer would be right there on the surface where everybody could see it and David Stockman would not be upset.

[The referred to recommendations appear at p. 115.]

Mr. **Edgar**. It would also be helpful if you could give us some quick analysis of the VA's aging report. Is it adequate? Have you had a chance to take a look at it in relationship to your studies? I was frustrated that there weren't specific recommendations in that aging report of much detail.

Dr. **Rowe**. I would be happy to—not happy, but I am willing to comment.

I remember the last time I was testifying before your committee you talked about it starting off as a plan, then a report, then a memo. I think that the report was factual and it reflects the very difficult situation that the Veterans' Administration is being placed in by virtue of pressures from this group and the administration and the funding people and their goals of responding to the challenge of the older veteran. I think within the context of that, while it was not as specific in terms of how we should move forward as I would have hoped, it was factual.

I think, also, that this group, while you're certainly behind the older veteran, is a little quick to criticize the VA in terms of some of what it does in geriatrics, and it would be useful to look past the VA at the rest of American medicine which hasn't done anything yet and really hasn't woken up yet. While it is difficult to change a system like the VA, I think they have shown that they can change.

So I am a little more bullish about the people behind the report than I am the report. I think that's the important issue.

Mr. **Edgar**. Are there any additional questions? All right, we will excuse you at this point. We appreciate your testimony.

Dr. **Rowe**. Thank you. I appreciate the opportunity.

Mr. **Edgar**. Dr. Custis, we appreciate your patience this morning and we look forward to hearing your statement at this point.

STATEMENT OF DONALD L. CUSTIS

Dr. Custis. Thank you, Mr. Chairman.

Mr. Chairman, I have a 7-minute summary of my full statement, if you will.

I thank you for the privilege of testifying at this hearing before the Select Committee on Aging and the Subcommittee on Hospitals and Health Care. The joint nature of this hearing is in itself a recognition of the interrelationship of long-term care medical issues involving both the veteran and the nonveteran, as well as the commonality of interest between the VA and the private sector health care systems.

The size and demands of the Nation's aging phenomenon are not easily grasped, but the implications as extensively detailed in the medical and socioeconomic literature are certainly arresting. Ramifications of what has been called the longevity revolution are so broad and complex that it may well become the most compelling imperative driving the socioeconomic, political, and ethical aspects of tomorrow's health care industry.

The data is irrefutable. Denial of its validity would be amusing were the consequences not so serious. To ignore the problem will certainly not make it disappear. The choice, as Dr. Rowe has just stated, for the VA and for the Nation is not whether to deal with the problem but, rather, how do deal with it.

Although this is not the place for an extensive recital of demographic data, we are all aware of the fact that the percentage aging of the 29 million veterans will occur at three times the rate projected for society at large and will fully impact a decade before it peaks in the general population; 11 percent, or 3 million veterans, are currently over age 65, and by the year 2000 will reach 37 percent. In that year, two-thirds of all American males over the age of 65 will be military veterans.

Mindful of this prospect, the VA Department of Medicine and Surgery began its study of the aging veteran impact 8 years ago and published its initial analysis in 1977. Subsequently, a decentralized strategic planning process called MEDIPP was designed and implemented throughout the VA health care system. A supplementary effort resulted in the publication last year of a planning document entitled "Caring for the Older Veteran," which has been referenced repeatedly this morning. It was the result of more than 2 years of study, advisory input, contract consultation and review. The plan provided an overview based on demographic projected need of the opportunities presented by the aging of its constituents.

Unfortunately, this document failed to receive sanction as a strategic plan by OMB and was modified accordingly. All requests for incremental geriatric program implementation were denied in the fiscal year 1986 proposed budget.

"Caring for the Older Veteran" remains, however, a valid, demographic needs assessment. It was never intended that the VA health care system alone could achieve sufficient growth and resource capability for independent and complete satisfaction of this need. For this reason, other options were proposed for a greater dependency on contract care and sharing of facilities with the private sector.

Most notable was a proposal to permit the VA to engage in joint cooperative efforts with local communities to develop and share noninstitutionalization programs for the aged veteran and nonveteran. It was further suggested that Congress consider the provision of seed money to encourage the creation of such cooperative community geriatric structures in a manner not unlike that provided for the AHEC's, the area health education centers.

Mr. Chairmen, your committees are to be commended on your effort to consider in some depth the underlying policy issues inherent in this aging phenomenon and hopefully to influence the focal point of Congress in further health care legislation. But certainly continued horizontal leveling of the VA health care system through arbitrary and, I might say, insensitive budget decrements will render it impotent to handle its share of the impact of the aging veteran. The time has come for Congress to better define what the VA's share is, and how it can best be handled.

Those decisions should be made in the context of a comprehensive review and strategic reform process applied to all of the interrelated Federal health care programs addressing the needs of the elderly and the disabled.

The case for just such a review is well made in an excellent article appearing in Health Affairs by Dorothy Rice, the previous director of the National Center for Health Statistics, and Carroll Estes, consultant to the U.S. Senate Committee on Aging. They contend that because of the changing composition of the elderly population the time has come when Congress should consider not simply spending reductions but the very structure of Medicare itself.

The proposal of Rice and Estes is ambitious, but the aging revolution and its coming impact on the Nation's health care systems justifies truly extraordinary measures to ensure the availability of required resources. To repeat, the veteran population aging cycle is running a decade ahead of that for the population in general. This provides a unique opportunity to design and test optional models to serve the needs of the elderly in the VA's controlled environment.

Because of the interest of the private sector in the success of such research, and because of the VA's interest that society in fact develop programs which are then available to veterans, I would hope that your combined committees would consider the establishment of a congressional commission on program review and health policy revision for the aged. Such a commission should have a broad base of representation from all appropriate vested interests. Its purpose would include the analysis of different health care models, review of existing systems and the development of recommendations for congressional guidance in the possible redesign of Federal programs and the establishment of coherent health care policy for the elderly and disabled.

Incidentally, there is a historical precedent in such a commission, I submit. The Bradley Commission, after World War II, gave birth to the Department of Medicine and Surgery in the Veterans' Administration and literally brought veterans' medical care into the 20th century.

Unless the advocates of the elderly and disabled address the policy issues critical to their needs, their future will be shaped by the advocacy of others. The time for a congressional review is propitious, particularly for the VA.

If there is any foregone conclusion about the impact of the older veteran, it is surely this: The cost of veterans' health care will significantly increase. The coming demand for care for all elderly citizens must somehow be met. What all of us seek is not really cost reduction but, rather, cost economy, with proper allowance for compassionate care. A concerted effort is needed to avoid the transformation of what has been or should be a humanitarian service into a business endeavor where the laws of economics may well become the all-controlling influence for health care policy. Should that happen, Mr. Chairman, the longevity revolution will become a forced reminder of humanitarian neglect and a national shame.

[The statement of Dr. Donald L. Custis appears at p. 118.]

Mr. EDGAR. Thank you, Dr. Custis.

I happen to like your idea of a National Commission on Health Policy for the Aging. It's an idea that kind of sprung forward out of our discussions in setting up these hearings, as well as underscored in your testimony.

Have you given any thought to how the Commission would be shaped or formed and how you would envision the structure of that commission, and what Government entity would you suggest be affiliated with such a commission?

Dr. CUSTIS. I would answer the last part of your question first, Mr. Chairman. It seems to me that it would be very important, if you are going to avoid bias, that the Commission be responsible to committee or committees in the Congress and not to a Government agency. I think we have examples now in Government agencies where policy is being pursued in a very biased fashion.

I think it is also important, in answer to your question, that there be representation from the constituency that is involved in such planning. I think it should include the private sector as well as representation in Federal programs for the aged. I think it most important that Congress have some of their members on the steering committee to give guidance to the efforts of this commission.

Mr. EDGAR. I happen to like the Commission idea because I think, while there was pain with the Social Security Commission, it, in fact, did a job in looking at the options. I know Congressman Claude Pepper has an idea to have a Medicare Commission to look at the long-term options for Medicare. I think the Comission structure does give you a chance for an institution to be formed that will, in fact, die at the end of a fixed period of time but would bring together a blue ribbon panel of experts and providers and constituent groups, but also be able to lay out some of the tough options that might have to be addressed in developing a long-term health policy for the aging. So I look forward to pursuing that with you.

I have one further question. Last year the Veterans' Administration, while you were the chief medical director, in responding to questions from the Senate Appropriations Committee—and I believe Senator/Astronaut Jake Garn was the questioner—the VA indicated, quoting from pages 639 and 646 of the testimony:

> There would be no cost savings to the Government if the nonservice-connected workload was shifted to Medicare or other related programs.

Then the VA went on to say that:

> Rather than save funds, such a major change could trigger an escalation in health care costs for the country as a whole and jeopardize health care for the elderly disabled and medically needy.

In fact, the VA suggested that it might be more prudent to have Medicare consider purchasing services from the VA.

Dr. Custis, from the standpoint of Government savings, would it, in fact, make more sense for Medicare to reimburse the VA for care, rather than shift veterans over to some other system? Has the VA looked into this and have you had any opinion about the way in which the Veterans' Administration and Medicare should be related?

Dr. CUSTIS. I am mindful immediately, Mr. Chairman, of historically veterans' service organizations having considerable anxiety about mixing payment systems of Medicare and veterans' health care, for what I think are very good reasons. I had the same feeling about third party reimbursement to the extent that conceptually it doesn't seem to me to have much rational basis. It is merely a shifting of costs for veterans' care from the taxpayer to the insurance payer. Plus the fact that in my experience, and based on surveys that the VA has done on the average of every 2 years, there is no doubt in my mind whatsoever—although the point is argued—that veterans' health care is more economical than what is offered in the private sector by at least 10 percent for comparable diagnostic entities.

So my own reaction to your question would be that it would be not only more expensive but also, for other reasons, would be something I would not want to see happen.

Mr. EDGAR. Mr. Roybal.

Mr. ROYBAL. Dr. Custis, I also am very interested in your comments in regard to a congressional commission on program review. You made reference to the Bradley Commission and I remember reading of some of the accomplishments of that Commission years back. I agree that this is something that should be considered.

However, we have still to look into the structure of this commission. How was the Bradley Commission structured? Was it under a committee of the Congress?

Dr. CUSTIS. It is my understanding that it was a congressional Commission, yes, sir.

Mr. ROYBAL. It was under the Congress at that time.

I don't remember whether it was a large Commission. Do you remember what the size of the Commission was?

Dr. CUSTIS. I would like, if I may, to refer the question to Mr. Rufus Wilson. I am sure his corporate memory is greater than mine. [Laughter.]

Mr. ROYBAL. I would like to get an idea how big that Commission was and then go on to another question. Will you answer that question, please?

Mr. WILSON. Mr. Congressman, as I recall, it had nine members on it. It was chaired by General Bradley. A man named Clarence Adamy was on it, General Donovan of OSS fame in World War II, and a group of other people, not from the Government sector, as I recall. It was in 1955 that it was established, after the second Eisenhower election.

Mr. ROYBAL. The point I'm getting at is that the word, "commission," implies a large number of people. I remember that the Bradley Commission was not large—I thought it was 11, but it's 9—and a commission of that number I think can work. If it gets too large, it's not going to work in my opinion.

What do you think of that, Dr. Custis?

Dr. CUSTIS. I think that's absolutely true.

Mr. ROYBAL. We are in agreement then that the size should be small and that we should look into this matter of a commission. I would be happy to cooperate with the chairman in conducting a little study on this idea.

Mr. EDGAR. Would the gentleman yield?

Mr. ROYBAL. I will yield.

Mr. EDGAR. I have some experience in establishing the National Groundwater Commission. We, too, wanted to have a very small Commission. Then committees of the House and Senate decided they wanted to be part of it and, of course, you had to have a Democrat and a Republican as part of the Commission. So we actually have, I think, about a 9- or 11-member Commission. The rest are Members of Congress from appropriate committees of jurisdiction.

I think if we can restrict our involvement on the Commission and try to focus it on the people who can make a real contribution, while we still keep an umbilical cord to it, I think your instincts are right. It ought to be small and it ought to be efficient. There ought to be a timeframe at which the Commission has to report its options and it ought to have sufficient resources to develop those options.

Mr. ROYBAL. Dr. Custis, we have been told about a so-called fair means test that is now being considered. What effect will such a policy or means test have on the delivery system for the veteran?

Dr. CUSTIS. Mr. Chairman, first and foremost, it strikes me strange, indeed, that the 1986 budget should contain such a whopping decrement for a means test that has not even been put in place yet. The means test, as I understand its current status, I think is seriously flawed.

In the first place, I think it is a mistake to claim that a means test is a cost-containment mechanism or will cut back on the volume of veteran care in the system. I think that for every individual veteran that is found to be, through a means test, able to pay for private care, his place is going to be filled by three or four veterans who are in line right behind him trying to gain access to the system.

As to the component elements of the means test as it currently stands, it will, in my opinion, cause tremendous furor throughout the system in the admitting milieu. To have every nonservice veteran take such a test before consideration for admission is going to be administratively a nightmare. It at the present time is expected to be prospectively given instead of retrospectively applied. Were it to be retrospectively applied on some judicial basis, it could work. As a matter of fact, if you could design an equitable, flexible means test, I think it probably would be a good tool and I would favor it.

However, to do a cost comparison for the individual veteran as regards how much money his medical care is going to take for the episode in question, in a prospective way, there would be a very cursory, superficial physical exam given and a diagnosis applied that, at best, would be something less than definitive. If it were done retrospectively, after a complete diagnostic workup, then you could, indeed, do a valid cost comparison between private sector charges and VA costs.

The means test, as it currently stands, does not take into consideration any protracted illness. It focuses exclusively on the immediate problem, and it is inequitable as far as geography goes. The income of a veteran will go a lot farther in a rural setting in the Middle West than that same income for a veteran in Manhattan.

Finally, I think it is faulty in that it does not provide for an appellate process, as most benefits for veterans do provide.

All of those things, it seems to me, could be brought under consideration and it is conceivable that an equitable, flexible, fair means test is possible.

I think the Veterans' Administration pays quite a price for this entitlement beyond the age of 65 regardless of the veterans ability to pay. It encourages the public to think that we have veterans driving up to veterans hospitals in Cadillacs and Mercedes, and that simply isn't true.

I would also predict that if an equitable, fair means test were designed and applied, that the same experience that we had up until the early seventies would be repeated, namely, that less than 2 percent of veterans taking the poverty oath would be found to be doing so invalidly. The truth of the matter is the veteran who can afford private care seeks private care, with the exception of a certain percentage of the service-connected veterans who have an extreme loyalty to the VA health care system. But for the nonservice-connected veteran who can afford private care, he invariably obtains private care. So I don't believe that a means test would materially affect the over 65 veteran utilizing the VA system.

That was a long answer to your question.

Mr. ROYBAL. But it was a very excellent answer. I thank you very much.

Mr. EDGAR. Thank you.

Mr. Smith.

Mr. SMITH of New Jersey. Thank you, Mr. Chairman. Dr. Custis, I do commend you for that exhaustive answer.

I have a couple of questions I would like to address to you. You observe in your testimony that to really care for the aging population of our Nation, including veterans, will require opening a 200-bed nursing home facility every day for the next 15 years just to maintain current levels. How many such homes are opening today and could you give us a realistic projection as to the level of construction of nursing homes that is doable in the foreseeable future?

Dr. CUSTIS. There are approximately 1,300,000 nursing homes in the United States today. I don't have the latest figure, but I think there remains several dozen States that have a moratorium on any further nursing home construction.

The AMA came out a year or so ago with the startling announcement that to keep up with the need of nursing home care, if the current levels of care were maintained, in the year 2000 it would require the construction of a 100-bed nursing home opening every day between that time and the year 2000. They later have realized that they have underestimated that by 100 percent, that it would take a 200-bed nursing home opening every day between now and the year 2000, that based on the Center for Health Statistics estimate that there will be required a 68-percent increase in the number of nursing homes by the year 2000.

Mr. SMITH of New Jersey. Do those studies or projections take into consideration the new emphasis on adult day care and other kinds of health care intervention?

Dr. CUSTIS. No, they do not. Those are based upon current levels of care and criteria for care. What they do is to serve to emphasize the importance of developing noninstitutionalized programs, adult day care centers and hospital-based home care.

Mr. SMITH of New Jersey. And question that is related, we heard that in areas with large bed shortages that State officials report difficulties in enforcing licensure standards and penalizing code violators. They state it often becomes less feasible, for instance, to suspend the license or transfer a patient when there are few places with available beds.

Would you care to comment on this problem, which obviously speaks to the issue of not numbers of beds but inadequate health care.

Dr. CUSTIS. I am not the best authority to comment on that. I do have, based on my experience and what I read, some general impressions that approximately 25 percent of all the nursing home beds in the country, were they subjected to the criteria and standards for accreditation of the joint commission, would fail to be accredited. Recently there was a survey in the State of Florida that showed a high incidence of something less than adequate quality of care.

Mr. SMITH of New Jersey. I would just note that in my State we had a very serious problem with this several years ago. John Fay, who headed up the investigation, found numerous problems with the standard of health care that was being provided and a very serious attempt was made by State officials to get those various nursing home facilities to upgrade their standards and their provision of services.

I have one final question. Am I reading your testimony correctly, Dr. Custis, where on pages 5 and 6 you express serious reservations about the spend down theory and you relate it to the proposed VA means test. Yet you also suggest that programs are needed to encourage consumer sharing of financial costs for long-term care.

Are you suggesting that the veterans possibly pay for part of their care in VA facilities, or part of the cost of other kinds of care provided under the VA auspices?

Dr. CUSTIS. Yes, Mr. Congressman, that's exactly what I'm suggesting. I think the idea of spend down from a near poverty level into a poverty level for the veteran and the nonveteran, the Medicaid requirement for spend down, is reprehensible. The point is made also by Rich and Estes in their article that, surely, this should be rethought.

It seems to me there should be consideration given to the nonservice-connected veteran who is in a position to help pay for his care but not able to pay for private care or the full copayment of Medicare, being required to spend down for a protracted illness until he is a welfare case, dependent upon VA care, when an earlier participation based on his ability to participate would obviate that spend down.

Mr. SMITH of New Jersey. I thank you, Dr. Custis. It is great to see you again.

Mr. EDGAR. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Dr. Custis. I appreciate your being here today and the forthrightness of your testimony and the thoughtfulness of the issues that you have raised.

On page 4 you comment that to reduce health care costs the Federal Government has invested almost exclusive faith in the efficiency of market principles. I would want to see the Federal Government in that context to very much include Congress, and I would say they have not invested their faith in market principles. They have used the rhetoric of market principles to mask what is in reality price fixing.

I want to pursue with you a little bit as to what you see the implications and the consequences are of arbitrarily fixed reimbursement rates. We see DRG's. We have now frozen DRG's. We have frozen Medicare reimbursements. We are only now pursuing that kind of course in Medicare. However, we have pursued that course for now some decades in Medicaid and we know that in Medicaid access to health care for low-income families has been significantly compromised by the fact that the reimbursements are unrealistically low.

With the advent of DRG's, there is now a mood in the private sector that they don't want to be cost-shifted on to any more. They want to be treated by the DRG system like everybody else, so that is going to eliminate that sort of escape valve that has preserved some availability of care for those whose health care depends on Medicaid reimbursements.

With that cap approach being now broadened to encompass all sectors of the health care system, I believe the evidence is there in Medicaid to indicate that it is going to compromise both access and quality. I have a very real concern that that's going to happen in Medicare and I wonder if you share that concern. I can enlarge on why I think this is happening in Medicaid, but I won't take the time to do that unless it seems to be necessary. But I think there is plenty of evidence to show that unrealistically low capped Medicaid reimbursements have compromised health care for that poulation, and I think we are now moving into an approach in Medicaid that is relying ever more on politically capped reimbursements and that it will end up compromising both health care in quality and access in that program, too. I wonder if you share my fears.

Dr. CUSTIS. I do entirely, in literally everything you said. I think there is a point beyond which this can't be permitted to go. I think organized medicine is warning that that point has probably already been arrived at—I'm talking about the AHA and the AMA. They are now on record as saying a further pursuit of this, without any consideration of the consequences, is just not going to be satisfactory.

The consequences, if it goes on, are going to be—in the first place, it has caused a lot of cost shifting. The third party payers aren't going to tolerate that much longer. The fixed price concept itself means that facilities, hospitals specifically, caught in that bind are going to be in more and more danger of going broke.

Mrs. JOHNSON. Why is it that the VA system——

Dr. CUSTIS. The third consequence I would want to identify—and I apologize for interrupting——

Mrs. JOHNSON. No, that's all right.

Dr. CUSTIS [Continuing]. Is uncompensated care and elements of society not having access to any care whatsoever. The interagency working group in the White House that is addressing health policy for America in their report has warned Congress to continue to ignore uncompensated care. Now, that I call insensitive. I suppose sensitivity is a judgmental matter in the last analysis, but the providers of health care in the United States are becoming more and more anxious that Congress had better start thinking about uncompensated care and how to handle it. Somebody has got to pay for it.

Mrs. JOHNSON. Just a brief follow-on question, if I may.

Recognizing the impact that capping reimbursements has had in the private sector, how do you explain the fact that the VA system can provide care for less than the private sector? Does that reflect your ability to regulate demand?

Dr. CUSTIS. I think the private sector is rapidly finding out on their own how the VA does it. With the vertical and horizontal integration that is happening in the private sector, with mutlihospital-management combines, large corporations that are in the for-profit provision of health care, are beginning to look like the VA in their comprehensive continuum of care, with large purchases as far as supplies go.

There are other things which give the VA advantages. The VA does not pay its professional help nearly as well as the private sector does, and probably will never be able to. That's an advantage.

Mrs. JOHNSON. Does it matter that the VA system doesn't have to accept somebody in a limited sense. I mean, I have seen to some extent in my VA hospitals, when the budget runs out for hip replacements or something like that, then the person has to go to the private sector or wait until next year's budget comes around. Now, this is also what you can see happening in England.

Is part of the reason you can provide service for less the fact that you simply are forced to live within your budget?

Dr. CUSTIS. I am sure that's true. As a matter of fact, that's the only way, as a last result, our hospital directors can stay out of the red in terms of handling their budgets, and that is the denial of care at the access point, either in quantity or quality of what care they choose not to absorb.

Mrs. JOHNSON. Thank you. I think that is really critical to understand that if you have a fixed budget system, you do in the end have to limit access and quality.

I just want to conclude my comments by saying I am also very much interested in the national congressional commission approach. I notice you do call it a congressional commission. However, I don't agree that it should have representatives from all vested interests. I think it should have representatives from the vested interests but also representatives from the nonvested interests. Because if the vested interests get together and create a strategy to achieve the best of all possible health care programs, it will not be implemented because the cost problems are so very real and serious. I think what is happening in the private sector is an indication of that. I think you need the vested interests, but you need the nonvested interests in there, too. I would want to see a broader base, but I hope we can work on something like that.

Thank you.

Mr. EDGAR. Mr. Ridge.

Mr. RIDGE. Thank you, Mr. Chairman.

Just a brief comment, if I might. I really want to thank you, doctor, for what I consider to be some rather forward-looking and progressive testimony. Congress, from time to time, proves it responds to a crisis and it is often a crisis-activated body. We knew Social Security was in trouble for some time but we waited until the 11th hour to form the Commission to take a look at the problem and work out the political differences and come up with a legislative solution.

You have identified two committees on which I am privileged to serve the Veterans' Affairs Committee and the Select Committee on Aging—to take a comprehensive look and a joint role in looking at the future of health care. There is the merging of senior citizens issues and aging issues and veterans issues, which I think is very refreshing. Given the leadership of the chairmen in both committees, I am hopeful and would suspect that we would get some response to that recommendation.

We know that the hospital insurance fund is going to have some difficulty, that there will be some problems, and we anticipate it's going to be early in the next decade. Your testimony highlights the tremendous pressure on the VA system with a tripling of male veterans who will be relying on the Medicare system or the VA system. So just as one Member of Congress who wishes that the body itself was a little bit more forward-looking in many of the areas, I want to commend you for your statement and your recommendation that we merge either these two committees or, as our chairman of the subcommittee has said, we will keep an umbilical cord today and in 1985, 1986 and 1987, to identify and prepare for problems that we know are going to occur in the next decade and in the next century. I want to thank you for that statement.

Mr. EDGAR. Thank you, Dr. Custis. I hope that you will get a vacation this summer and take some time off. I know that you left the VA and went right to work again, and we appreciate your assistance here in giving us some of your advice from your experience. I hope you have an enjoyable summer, and thank you for coming to testify.

Dr. CUSTIS. Thank you, Mr. Chairman.

Mr. EDGAR. Our final witness will be Dr. Ditzler. We appreciate his patience. I know you are accompanied by a number of your crack staff people and we will have those identified for the record.

I would indicate for the record that your entire statement will be made a part of the record at this point. We welcome you to this imaginary lunch. There is no food available, but we do have some liquid refreshment in the water that's on the table. We apologize for the length of time, although we believe we have received some good testimony.

If you will identify the people who are at the table with you and summarize your statement for us, we then can move to questions and conclude this hearing.

STATEMENT OF JOHN DITZLER, M.D., CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; ACCOMPANIED BY JOHN MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE; MARJORIE QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR ADMINISTRATION; JAMES GREGG, DEPUTY DIRECTOR, PROGRAM ANALYSIS AND DEVELOPMENT; AND AUDLEY HENDRICKS, OFFICE OF THE GENERAL COUNSEL

Dr. **Ditzler**. Thank you, Mr. Chairman.

To my far left, to your right, is Midge Quandt, who is our Assistant Chief Medical Director for Administration. To my immediate left, your right, is Mr. Jim Gregg, who is Deputy Director for Program Analysis and Development. to my extreme right, your left, Mr. Audley Hendricks, legal counsel, and to my immediate right is Dr. John Mather, who is the Assistant Chief Medical Director for Geriatrics and Extended Care.

I feel like Daniel in the lion's den, only the lions don't have very high blood sugars, so I will try to make my oral statement brief.

I am pleased to have the opportunity to discuss this serious challenge of providing health care to the aging veteran and opportunities that result from interaction of policies for older veterans with policies of other Federal agencies.

All agencies of Government that deal with the elderly have to meet the challenge of distributing resources most effectively. Moreover, the challenge carries with it a responsibility for the VA to develop and demonstrate effective approaches to the care of older veterans which can be observed and adapted by society as a whole.

My formal written testimony details the VA's current understanding of that challenge. It also discusses the complexity of planning for the future and the relationship of the veterans' health care to other Federal programs and the efforts that are currently underway to cooperate with other Federal agencies and programs, national as well as at the local levels.

In approaching our challenge relative to the care of the older veteran, we have encountered a potential inequity in the law governing eligibility for VA medical care. We appreciate, therefore, your providing this opportunity to discuss our legislative proposal to remedy that inequity.

As you know, we recently submitted to the Congress a draft bill that would revise eligibility for VA medical care, but let me set that in context as follows:

Historically, the primary mission of the VA health care system has been to furnish care to service-connected disabled veterans and to veterans unable to pay for medical treatment. In 1970, however, Congress extended eligibility for VA hospital and nursing home care to veterans 65 years of age and older without regard to financial need. In sharp contrast, legal eligibility of most nonservice-connected veterans under age 65 is based on their inability to defray the cost of needed medical care.

The law's disparate treatment of nonservice-connected veterans on the basis of age alone raises a serious issue. The VA may only provide medical care to nonservice-connected veterans to the extent facilities and resources are available. Demographic projections indicate that the number of veterans who will be eligible for care as the veteran population ages is increasing significantly. Fairness dictates that age alone should not be a basis of entitling one to VA care. Rather, VA should be treating those nonservice-connected veterans who lack the means to obtain such treatment elsewhere, regardless of age.

The VA draft bill, accordingly, is intended to overcome this inequity.

The change would also clarify and extend a framework which Congress provided for in 1980 when it enacted Public Law 96-330 and deleted provisions of law prohibiting the VA from looking behind the veteran's assertion of financial need.

Thus, the bill would specifically provide for the Administrator to promulgate regulations identifying the conditions under which veterans may be considered unable to defray medical expenses. It would also establish in law that a nonservice-connected veteran whose total income and assets are below an eligibility level set at twice the VA pension rate—currently just under $15,000 for a veteran with one dependent—would be deemed unable to defray the cost of needed medical care.

Enactment of this proposal would enable VA to develop a fair, effective screening system to help assure that those veterans with the greatest need—that is, the service-connected and financially disadvantaged veterans—can avail themselves of VA care.

Messrs. Chairmen, you also asked that in preparing for this hearing we develop an analysis of the impact of our legislative proposal. As regards your questions about Medicaid impact, if a nonservice-connected veteran can establish entitlement to Medicaid assistance, that individual is deemed, for purposes of VA eligibility, unable to defray such expenses and would be admitted to receive VA medical care.

However, VA medical care is not intended to be a substitute for Medicare, for veterans with Medicare coverage and incomes above double the annual VA pension rate. We anticipate that these veterans would first seek care available to them through Medicare coverage. However, after these veterans make out-of-pocket expenditures up to the specified medical expense contribution, they would be eligible for VA care. Veterans with Medicare eligibility and incomes below double the pension level will be admitted to VA facilities whether or not they have first used up their Medicare benefits.

We do not foresee that the implementation of this proposal to revise medical eligibility would in any way impair the quality of VA medical care, or of its research and of its education programs. We are confident that the enactment of this proposal would assure fairness and permit the VA health care system to be more responsive to those veterans with the greatest need for and the highest claim for its services.

Mr. Chairman, this concludes my oral presentation. I remain ready with my staff to try to answer your questions.

[The statement of Dr. John Ditzler appears at p. 121.]

Mr. **Edgar**. Thank you very much.

Dr. Ditzler, are you aware of a March 14 letter that we sent to Harry Walters requesting in paragraph 2, "In preparation of this hearing, we are requesting that the Veterans' Administration prepare a report on the impact of the VA eligibility reforms being considered by the administration on the individual veteran, on the VA, Medicare and Medicaid costs, and on the quality of VA medical care."

Dr. **Ditzler**. I know that such a letter was received.

Mr. **Edgar**. Dr. Ditzler, are you familiar with the response that we received from Harry Walters, dated April 18, which says, "While we have initiated the interagency coordination you requested, I am disappointed to report that the complex analysis you had hoped could be furnished to the committees by April 12 remains incomplete"?

Dr. **Ditzler**. I knew that such a letter was in preparation, yes.

Mr. **Edgar**. Since it is now the 23d of April, do you have the report, the data, the information that we requested with you?

Dr. **Ditzler**. Regrettably, no, sir. The basic reason, at least from my point of view, is that it will be difficult to obtain such data until such a system is in place. I believe I heard Dr. Custis also mention the fact that there may or there may not be a non-service-connected patient filling a bed after hypothetically displacing somebody who theoretically drove that Cadillac.

Mr. **Edgar**. Are you suggesting to us, then, that we in this committee—not the Select Committee on Aging, but the Subcommittee on Hospitals and Health Care—accept the recommendations of the administration without at least a projection of the data required to understand the savings, the number of veterans affected, how many veterans will not be serviced in the VA because of the proposal; is that your suggestion this morning?

Dr. **Ditzler**. I am suggesting, sir, that the basic reason for this proposal is fairness. We have a belief that the Congress has the opportunity to enact the legislation based strictly on fairness of the approach. What it's impact will be, I very frankly don't believe any of us have a complete data base to present at this time.

Mr. **Edgar**. Let me ask you some specific questions, then.

How many non-service-connected veterans over the age of 65 will be affected with the means test in place?

Dr. **Ditzler**. I really don't know. We have had many attempts to find an answer and it remains a matter for speculation.

Mr. **Edgar**. So you don't know the answer to that question?

Dr. **Ditzler**. No, I do not.

Mr. **Edgar**. How much will we save in fiscal 1986 if this program is put in place?

Dr. **Ditzler**. I would hazard to guess that we may not save anything, but that again is speculative.

Mr. **Edgar**. How did you determine that you might not save anything?

Dr. **Ditzler**. Well, I think as an ex-hospital director, speaking personally, I would have to imagine that some of the testimony that you have heard this morning, whether it be dumping of patients or however it has been defined, it is still going on. Until we have actual experience with this, I don't think I can give you an accurate figure.

Mr. **Edgar**. I appreciate your honesty and sharing the fact that you don't know the number that are going to be affected or the amount of savings that is going to take place.

I have in my hand, which I would like to submit by unanimous consent for the record, to all Republican Senators and legislative directors, from Steve Bell, staff director, reference the Senate/White House deficit reduction agreement, dated April 5, 1985. This is the document that was put together as an agreement with the White House and with the Republican Senators in terms of the budget proposals.

[The referenced memorandum appears at p. 125.]

Mr. **Edgar**. Now, as I share this document, I would like to submit this memorandum for the record because in the memorandum it clearly states that $400 million of savings is proposed by reforming the VA hospital and medical care system. This savings would result from two reforms: First, the means test for non-service-connected veterans, regardless of age, and second, cost recovery from the private insurers of non-service-connected veterans for care delivered in VA facilities.

Now, I can't understand how the Senate and the Senate Republicans and the White House can pick a number out of the air, not a little number, but $400 million, and brag on themselves about saving that for the American taxpayer by instituting these two reforms; and yet the VA cannot provide to this committee on the House side, who has the same responsibility, any back-up documentation, any demographic information, any supporting data for the recommendations that are being made.

I just wonder whether or not you can explain to the committee how such an important change in the way in which the VA does its business can, in fact, be implemented without our having the supporting data in place.

Dr. **Ditzler**. I would like to see the supporting data, also. I have not seen that document to which you refer and I cannot identify any figure in that cost savings that is familiar or I have seen before.

Mr. **Edgar**. Is there anybody here in the audience from the Office of Management and Budget who might be able to assist us in finding out where this $400 million is from?

[No response.]

Is there anybody here from the CIA who might be able to——

[Laughter.]

I think I have made the point, that these are significant changes. I respect your opinion as to how they might be helpful in the long term, but I really find it very difficult. In my 10½ years on this committee, I don't remember a time when we have been asked to change a policy so significantly as the means test and as the third party reimbursement with as little cooperation and as little supporting data as we have received at this point.

Mrs. JOHNSON. Will the gentleman yield?

Mr. EDGAR. I yield to the gentlewoman.

Mrs. JOHNSON. Have you not been collecting on intake, then, income data for non-service-connected veterans over 65?

Dr. DITZLER. We never collect income data on anybody that is exempted by law, which is currently the law for all over 65.

Mrs. JOHNSON. So it simply is the fact that the data is not there and there is no way that you could know or predict accurately what the savings would be; is that not so?

Dr. DITZLER. We are not speaking to this as a matter of cost avoidance or of savings. We are speaking to it simply as a fair way to approach eligibility.

Mrs. JOHNSON. I appreciate that that's the case you are making, and I think that is the issue we should decide. Nonetheless, I do think the lack of retroactive data does not totally limit our ability to imagine what in the long term might be the impact. Because we have been given statistics here by witness after witness after witness as to the increase in the number of veterans who are aging, and we know that along with that goes an increase in care demand, and so on and so forth. So we certainly know that as the demand for care increases in the VA sector, that this kind of proposal will make a difference in the costs that the system is required to bear.

So while we can't necessarily say it's going to be a savings of $400 million, in making our budget it is important that we acknowledge that, that the savings may be zero 1 year, zero the next year, but that ultimately I think it is fair to say—whether this is part of the rationale for the proposal or whether it isn't—would you agree that it will have an impact on cost growth of the system?

Dr. DITZLER. Are you asking for my personal opinion?

Mrs. JOHNSON. I am asking for your opinion as a former hospital Administrator and also as Administrator of the VA health care segment. Would you anticipate that it would affect demand for service and, therefore, cost of the VA system?

Dr. DITZLER. I really have to get back to the fairness question, because the problem the average hospital director has is managing the large number of people that come to a VA facility and administering their eligibility fairly. If he knows that he is complying strictly with the law it makes it much easier to run a hospital.

Now, whether it cuts down on our rate of growth or whether, as Dr. Custis testified, there will be another non-service-connected patient for the one who may have been excluded, it remains to be seen. I don't know.

Mrs. JOHNSON. A good point. So what you're saying——

Mr. EDGAR. If the gentlewoman will yield back just for a moment—I understand what you're saying, Dr, Ditzler, that this is not a question of savings; it's a question of fairness.

Dr. DITZLER. That's my point of view.

Mr. EDGAR. The other part of the question of fairness, though, is what should the Medicare system begin to anticipate will be additional costs that they will have to bear——

Dr. **Ditzler**. That's a very fair question, and I attempted to answer that in the formal written document, in which I indicate that under Medicaid we are going to continue to take the same individual who is eligible for Medicaid. Under Medicare, the only ones in which there will be a shift to Medicare are those veterans who are currently making over double the pension level and are currently under Medicare anyway. The shift will be minimal.

Mr. **Edgar**. I'm not certain why the Veterans' Administration and Health and Human Services and the Office of Management and Budget, with all of its technology and techniques and modeling ability, could not, if it is such an insignificant number of shifted dollars, make some general estimates.

We receive estimates all the time on the defense budget, how much it is going to cost for a particular weapon system or how much a particular service is going to cost in terms of retirement benefits in the military.

Why, if you want to make this change out of the word "fairness," we can't receive some data, some data points, in which we can judge whether or not it's going to be fair or unfair to the veteran.

Let me ask another question and then I will yield to my colleagues. That is, you already have the ability, under current law, right now, to put a means test on for those below the age of 65; is that not correct?

Dr. **Ditzler**. The Congress did pass a law, I believe 3 years ago, which instructed us to develop some sort of a means test. We have been very carefully trying to develop all points of view on this and we have in the interim assumed that in a sense we have had a means test by the oath. So this was the best attempt at resolving the issue.

I would like to ask Mr. Hendricks, our legal counsel, on the state of the law before I came here, please.

Mr. **Hendricks**. I think he has answered the question essentially correctly, that we can implement a means test under Public Law 96-330, which was 5 years ago. And as Dr. Ditzler indicated, there is a test in effect that may not be a totally efficient test, that is, the oath of poverty that the witnesses have referred to that the applicants still sign. In the meantime, much study has been given to amending that test to make it more efficient.

Mr. **Edgar**. If the means test is so fair—and we're only talking in this law about changing it for those over the age of 65—and if for 5 years you have already had the ability to put a means test in, why don't you put the means test in place, given the law that you have already available to you, and let's see what its impact is, and then let us judge whether or not applying that means test to those over the age of 65 is fair, is equitable, and does meet the needs of the long-term service of the Veterans' Administration.

I just don't understand why, if you have the ability already, why you are now coming back to us and asking for the ability to do it for those over the age of 65 when you haven't even put in place a reasonable, fair means test for those below 65, which you already have.

Mr. **Hendricks**. I can only say that the Congress gave us that law in 1980, and as I am sure the committee is well aware, it evoked much disagreement, much debate. Much study was given to it within the agency and there was much disagreement within the agency. There was much external disagreement as to how to implement that law.

In the meantime, there was extant a means test, and that is the oath of poverty. At least one witness testified it isn't too bad. It works. We don't have very many people getting care for which they are not eligible. I guess it is just a question of national policy, a major policy change being implemented through internal agency policies, or whether it should be debated in an open forum, a more national forum.

Mr. EDGAR. I appreciate your answer. I am going to yield to my colleagues, but I still have a great deal of frustration, because when these two proposals came forward on February 4, and when the Veterans' Administrator testified, when Dr. Ditzler testified, and we have been all in preparation for the legislation which you were going to introduce on these two provisions, the original discussion was not around fairness. The original discussion was around cost savings and the ability to save a chunk of money. We have had a great deal of difficulty under that premise of figuring out what the chunk of money is going to be and what the offset is going to be of shifting programs to other programs. We have had a difficult time feeling that chunk of money savings.

Now I hear you coming in and saying that doesn't matter, it's not really a money saver, at least up front in the open years, that it's really a question of fairness. I hope that you will go back and indicate to Mr. Walters, and I hope that Mr. Roybal's and my letter back to Health and Human Services will get some action, because I can tell you, as chairman of this subcommittee, I am going to find it very difficult to even think of holding a markup session on your legislation if, in fact, you can't justify that legislation based at least on a reasonable projection of the cost and the impact on the veteran.

I yield to the chairman.

Mr. ROYBAL. Thank you, Mr. Chairman.

Dr. Ditzler, I would like to thank you and your colleagues for being present this afternoon and testifying before this committee, but I must join the Chairman in expressing my disappointment in the absence of a witness that was to be here today from the Department of Health and Human Services. The Department claims it cannot speak on the issue of the aging veteran.

What we wanted to do is quite obvious. We wanted to learn from them, first of all, what was their position on the relationship between their functions with respect to Medicare and Medicaid, and the proposal means test for older veterans—all issues of great importance to the veteran and to the country. It is regrettable that they saw fit not to be present, but I hope that in the next few days, weeks or months they will make available to this committee and to the Congress the information needed to study this issue further. The question of a means test for veterans will ultimately get to the Committee on Appropriations, which I am a member of, and it is at that particular level that we will examine the situation more carefully.

Doctor, I have a lot of trouble with your argument with regard to fairness. Fairness, to me, means fairness all the way through. It sounds good, but when it comes to the application of the means test, I am at a loss as to what you mean by fairness.

First of all, is it your understanding, or the understanding of the Veterans' Administration, that most people over 65 years of age are wealthy?

Dr. DITZLER. No, sir.

Mr. ROYBAL. Isn't it true that the vast majority are poor, and isn't it true that if the proposal now to decrease Social Security, providing only a 2-percent increase, that approximately 570,000 senior citizens would fall under the poverty level?

Dr. DITZLER. I believe you are correct.

Mr. ROYBAL. Well, can we establish then, as a matter of fact, that the vast majority of senior citizens, particularly those over 65 years of age, are not wealthy, that they are people who may be needing the care that the Veterans' Administration is designed to give?

Dr. DITZLER. Let me identify a little bit further what I mean by fairness, and let me speak now removed as the Chief Medical Director, as a hospital director. The difficultly comes in turning people down. The turning down of people, irrespective of whether they're over or under the age of 65, is always a difficult problem. But a hospital can be run only so far on whatever funds it is allocated. When someone is turned down, it always gives a tough feeling in the minds of the people and, therefore, one always has to be sure you're doing it fairly.

The easiest way to make fairness outstandingly visible across the country nationwide, universally, is to have everybody essentially following the same guidelines. The guideline of establishing the eligibility without a means test for all service-connected veterans, for all ex-prisoners of war, for all those claiming problems relating to agent orange or radiation, or those on pensions, is clearly established and codified.

The only thing that remains to be clarified is the question of fairness regarding eligibility for nonservice-connected veterans under the age of 65. That's the issue of fairness.

Mr. ROYBAL. Well, that sounds very fair. Now comes the issue of a means test. To apply a means test, you must first determine whether a person can afford treatment elsewhere. Having been a social worker myself, I know what a social worker has to go through to make that determination.

To what extent does your social service department establish the fact that an individual is either indigent, falls under the poverty level, or is, indeed, unable to pay for that service?

Dr. DITZLER. At the current time not very much, because we do not look behind the oath. We accept the declaration as fact.

Mr. ROYBAL. All right. But since you're in favor of the means test, how much it is going to cost to implement it and will there be any savings? You must know the answer to its cost because I understand your department has taken part in the Administration's study of this matter.

Dr. DITZLER. There is no dollar reflection in the 1986 budget either as to cost of doing this or of any savings that may have been achieved.

Mr. EDGAR. Will the gentleman yield at that point?

Mr. ROYBAL. I yield.

Mr. EDGAR. I must go to the chairman of the Budget Committee, Bill Gray from Philadelphia, and ask him for a budget mark for the Veterans' Administration. He will then, after we pass it out of the House, go to a conference committee with the Senate. The Senate has determined that there is $400 million of savings.

Are you advising me to say to Mr. Gray, that before he brings that budget mark back to the House, he must correct it by $400 million because there are no dollar savings in this area?

Dr. DITZLER. I would respectfully suggest that you might ask him where those savings are.

Mr. EDGAR. The Senate has already put them in in relationship to a discussion they had with the White House. It is not his question to ask where the savings are. It is his question to question the Senators to justify that $400 million. What I am trying to get from you is, would you advise me to tell him that that $400 million is an illusionary amount of money that doesn't really exist and should he fight to take that back down to zero so that we have a real understanding of what our deficit is?

Dr. DITZLER. Mr. Chairman, I don't mean to be obtuse, but I cannot identify in the 1986 budget any cost savings, nor can I identify the costs.

Mr. EDGAR. Thank you. I yield back to the chairman.

Mr. ROYBAL. The VA provided testimony at a hearing just last summer about three joint demonstration projects between the VA and the Administration on Aging that were under review by both agencies.

Now, what is the focus of these projects, what is their current status, and what other collaborative efforts are underway or planned between your two agencies?

Dr. DITZLER. I would like to turn that question over to Dr. John Mather, who is our geriatrics and extended care ACMD.

Dr. MATHER. Mr. Chairman, in the full testimony that Dr. Ditzler has provided, there is an explanation of those particular projects on page 6. To enumerate them, as we have been working with the Administration on Aging, they are specifically demonstrations related to Alzheimer's disease and the care of families, ways in which we could develop an expansion of community-based treatment alternatives, using case management models for working with communities, and finally, some kind of collaboration in the area of education and staff development.

As of this past fall, with the resignation of the then Commissioner of the Administration on Aging, the Administration notified Dr. Ditzler that they were going to place these particular projects on hold until such time as there is a Commissioner of the AOA appointed.

We have, nonetheless, through my staff continued the dialog at the staff level until such time as a new Commissioner is appointed.

Mr. ROYBAL. How does Alzheimer's disease fit into this in view of the fact that there has been no recommendation for funding for Alzheimer's disease in the last 4 years? It has been the Congress that has put it in. Have you made preparations for the implementation of such a program?

Dr. **Mather**. Mr. Chairman, we have for at least 5 years been targeting very special efforts in meeting the challenge of the veteran who is a victim of Alzheimer's disease.

Mr. **Roybal**. I understand that, but that was due, in part, to the fact that we in the Committee on Appropriations put money in.

What I am getting at is, since the administration was not involved in recommending the funding for Alzheimer's disease, I'd like to understand how you and the agency could have been planning for it.

Dr. **Mather**. Mr. Chairman, within the VA's health care delivery system we have considerable flexibility to take the initiative. Indeed, as early as 1975, when the GRECC Program got underway, we had two GRECC's that identified Alzheimer's disease research as a fundamental area of focus. We have continued to pay special attention to victims of Alzheimer's disease. Notwithstanding this, we recognize that other parts of the Federal Government has necessitated specific legislation to establish Alzheimer's disease centers through the National Institute of Aging and also special initiatives through the Administration on Aging's programs.

We have, I would repeat, continued to extend our work in Alzheimer's disease within the agency, and in this particular proposed demonstration with the Administration on Aging, we are examining how we can support the primary care giver, whether it is the wife or family. This is incorporated into the notion of respite care for those that are trying to take care of those who are Alzheimer's disease victims.

Mr. **Roybal**. Well, I am glad that that has been done because that was the intent of the committee at the time. I am pleased that some progress has been made with regard to Alzheimer's disease. We still have a great deal more to do and we hope that we will do it so that the Veterans' Administration can serve the veteran who may unfortunately have Alzheimer's disease in the family.

That's all, Mr. Chairman.

Mr. **Edgar**. Thank you, Mr. Chairman.

Mrs. Johnson.

Mrs. **Johnson**. I want to make sure that I understand what I think to be the implications of what you're saying and what Dr. Custis was saying before.

Since the VA health care system is a system for which we appropriate money and is basically a controlled cost system of providing health care, and if the dollars run out or limits come, then the system simply makes decisions about who is going to get care. In other words, it regulates demand because the supply of dollars is limited, unlike the community-based hospital system.

First of all, would you agree that that is a fair description of the VA health care system?

Dr. **Ditzler**. In general, yes, but there is a major exception I would state.

Mrs. **Johnson**. OK.

Dr. **Ditzler**. That is, there are many ways that a hospital, multiplied by the entire system size, comes to grips with the size of its budget. First of all, it knows about it 6 months before the budget year begins, so that one makes plans in a lot of areas. For example, if a hospital is running $300,000 or $400,000 behind early in the year, a good cost analysis may indicate it is because the hospital is not using generic drugs. So there are cost savings that are picked up constantly.

One of the final control mechanisms is that if all other cost control methodologies fail, then we can control our expenditures on the basis of the space and resources available concept. Limiting acess to care on that basis would be accomplished by applying priorities set in law, restricting the access of those on the lowest level on the eligibility spectrum. Although you are correct, that one of the final ways of controlling costs or expenditures within a finite budget might be the reduction of those who are taken care of, the statistics, nonetheless, would reflect that the budget workload relationship over the last several years, the workload has always gone beyond even what was predicted.

Mrs. JOHNSON. I appreciate your comments as to the fact that there are other ways of controlling costs and certainly you do utilize those, and that also the budget of the hospital is made with some awareness of the demand for service that that hospital is responsible for meeting. But I think the fact that it is, in a sense, a closed system, is part of the reason why this proposal will not have a dollar impact but is, nonetheless, reasonable for us to consider as a committee.

It seems to me that what I hear you saying is that you shouldn't be considering this just as a budget item, but you should be considering it as policy. When we get to where we have to make decisions on access, we need to have a public policy that governs it, and that policy should be based on need and fairness. That's why you need this legislation, rather than to control costs.

Dr. DITZLER. Yes, ma'am, I would agree with that.

Mr. EDGAR. Would the gentlewoman yield?

Mrs. JOHNSON. Yes.

Mr. EDGAR. I think that you're right in your analysis, but that is not the original purpose of this proposal. This proposal was sent up as a budget recommendation to save money, just as the third-party reimbursement proposal was sent up to save money. It is a budget figure, and much like Dr. Ditzler used the illustration of a hospital director who has got a difficult budget situation and has to make choices, we have been asked to make choices in terms of service to the veteran and change a policy that has been long standing within the VA. What we are hearing today is that the policy is being changed for fairness reasons, and that is one level of consideration. But the original intention, and the intention of the Senate Budget Committee, the intention of the Office of Management and Budget, my guess is the original intention of the administration, is that this is a budget saving measure and had little or nothing to do with fairness, although fairness was hoped, but in fact, it was a revenue reduction, that is, a reduction out.

What I am trying to get at is, putting the fairness issue aside—if we were going to deal with this issue only as a fairness issue, some of the comments that Dr. Ditzler makes may make some sense. The question is we are being asked to deal with this as a budget issue; we're going to save money by doing this.

The question that I think Chairman Roybal and I want to know is how much money are we going to save, on what basis of consideration are we going to save money, and when are we going to get the data.

Mrs. JOHNSON. I appreciate what you're saying. But I think the implications of what you're saying are that if there is no budget justification, then we needn't consider this. I don't agree with you on that. I think that there are those in the administration who have proposed this as a budget item and asked us to consider it for that reason. My recollection is that the first time I read any statement by Harry Walters about this, he was not justifying it on a budget basis. I could be wrong in that. But I certainly know that among his early statements was the policy matter rather than the dollars matter.

My concern is—and I don't agree with the administration on this, and I haven't agreed with them, that this will save money, partly because of the nature of the system and partly because I don't think there are that many people over that category out there using the system. So I have maintained that from the beginning.

But there is a lot of public misunderstanding out there. Some people in the administration have done us a disservice in bringing this up. But there are Members of the body who have done the public a disservice by continuing—and I'm not at all implying anyone on this committee or the Aging Committee—but there are Members who talk about this in the context of the Reagan administration out to get the veterans and its heartlessness. That is not the issue, either. The fact is, there are care decisions to be made; there are access decisions to be made; and they are going to get worse as this veteran population ages. Unless we set some policy, then we won't be doing our job.

I just think we have got to concentrate on the policy challenge. I have no problem with all of us having elucidated very clearly that the budget data is not there.

Mr. EDGAR. The Budget Reconciliation Act provides that by May 15 we have to act on legislation that does have a budget impact. I thank Dr. Ditzler for clarifying for us that we don't have to act on the proposal immediately, that we can wait for the required time to get the required data because it doesn't have a budget implication and, therefore, we are not confined to the May 15 deadline, that we're really talking about a separate issue. That is helpful clarification today.

Mr. Ridge.

Mr. RIDGE. Thank you, Mr. Chairman.

I appreciate your comments about how helpful the clarification was, but I don't think that in the consideration of this budget or a VA program that we ever want to exclude fairness from our consideration of the budget, regardless of whether or not there are any budget savings. So I think as public policymakers—and I see the difficulty that Dr. Ditzler has had in obtaining information—if this committee was convinced that fairness alone warranted the inclusion of this change or modification, it would certainly be appropriate to include it in the budget. It remains to be seen whether a case has been made in terms of fairness, but I certainly don't think we want to exclude the concept of fairness from the budget consideration because that's what the budget battle is all about.

Mr. **Edgar**. If the gentleman would yield, that is not my intention. My intention is to clarify if this is a budget proposal or if it's a policy change. If it's a policy change, then we are not under the same pressure that we are under if, in fact, we have to justify to the Budget Committee and to the Appropriations Committee a savings of dollars. This committee is going to be given a mark back by the Budget Committee and we're going to have to live within that number in terms of education, compensation, pensions and health care. There will be some who will come back to this committee and say "you have to make up a $400, or $500, or $600 million of savings someplace within the VA." There was the implication by what the Senate did that we would make that savings up by enacting the two proposals that the administration has suggested.

My only point in today's hearing is to try to really come to grips with that because, if we don't make up that $400 to $500 million of imaginary savings, then we're going to have to take it out of someplace else. The Appropriations Committee is going to put pressure on us to take it out of education, compensation, or other veterans' programs, or other parts of the health care delivery system. I'm not sure that Dr. Ditzler could live with us reducing prescriptions or new technology by $400 or $500 million.

The assumptions are going to be made in the budget that the budget reconciliation mark is going to be based on certain savings from third party reimbursement and a means test. I just don't want to get us in a bind 4 weeks from now or 6 weeks from now of having to come up with $600, $700, $800 million of savings that come out of other areas of the budget because we couldn't justify those savings in these two programs.

You're right, the budget should be fair, and the fairness question should be raised in the budget. All I am doing is playing the role of the accountant and saying at some point the account is going to come due and we in this committee are going to have to find out where that $400, $500 $600, $700 million is going to come from. That number if floated by the Senate, it is floated by the Office of Management and Budget, and I want to justify it before we have to eat those dollars.

Mr. **Ridge**. I appreciate your concern and I am sure you will, as the chairman of the subcommittee, be in a much better position and probably a much more persuasive position to argue that point because of the testimony that the doctor provided.

It is my recollection, Doctor, that you indicated in your testimony that since 1970 the Congress of the United States has said there are no income requirements if you're 65 years of age or older and you're a veteran, that you need not show income eligibility; is that correct?

Dr. **Ditzler**. That is correct.

Mr. **Ridge**. And is it also a fact that there is either a specific prohibition or no authorization for you to make a case management inquiry as to that veteran's income status; is that correct?

Dr. **Ditzler**. We have had authorization for a means test for under 65 years since 1980; regulations have not been published.

Mr. **Ridge**. So it would be fairly difficult, without either getting authorization approval or changing it. Maybe it is something we will want to take a look at, Mr. Chairman, because I think your request for information is a legitimate one, but if the Congress as a body has told the VA these services are to be provided without regard for income levels, it is fairly difficult for Dr. Ditzler. I think he's been very candid with us when he says he doesn't know where the other body came up with those figures. You're really not in a position to extrapolate anything from your own case management studies; is that correct?

Dr. DITZLER. That's correct.

I may have misspoken on 1980 as the date for going behind the oath. Mr. Hendricks?

Mr. HENDRICKS. Since the enactment of Public Law 96-330, there has been authority to look behind the oath. Section 401 of Public Law 96-330 deleted the language of section 622 of title 38 that signing of such an oath shall be deemed evidence of inability to defray. That language is no longer in the law so we believe we can now look behind the oath. It's still a very costly proposition.

Mr. RIDGE. I understand that and I appreciate your clarification of that point.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

I have no further questions. Thank you very much for your testimony. The hearing stands adjourned.

[Whereupon, at 1:55 p.m., the joint hearing was adjourned.]

APPENDIX

STATEMENT OF HON. BOB EDGAR, CHAIRMAN

Good morning. Welcome to the joint hearing of the Subcommittee on Hospitals and Health Care of the House Veterans' Affairs Committee and the House Select Committee on Aging. This joining of efforts with my colleagues on the Subcommittee on Hospitals and Health Care and the Select Committee on Aging indicates our concern with the magnitude and complexity of the phenomenon often called the "Graying of America" and the "Aging Veteran". Such glib labels belie a phenomenon which is so large and so complex that it is difficult sometimes to even envision it.

Today we intend to receive testimony in a few context which I believe will help us learn the administration's decisions on national policy for health care. I hope these decisions do not simply shift the burden for care from one budget to another and do not create gaps in the kinds of services offered nor in the eligibility for those services. This new context will examine problems and opportunities that result from the interaction of policies for older veterans with those for the elderly at large. In a very real sense, the policies which are implemented by the Veterans' Administration for veterans should interact with policies implemented in other agencies. Since the veteran is growing older at a somewhat faster rate than the rest of the population, and since the VA provides services to a large number of our citizens, there is a special need to investigate the effects and interactions resulting from changes in eligibility and the range of services offered by the VA.

There will be three general topics addressed today.

One topic will be the distribution of resources to meet the needs of the aging veteran within the VA and other Federal agencies. We have received a major report from the VA entitled, "Caring for the Older Veteran." A comprehensive strategy is laid out in that report for planning and implementing changes in the VA to accommodate the great numbers of older veterans which are anticipated in the very near future. However, the budget proposed by the administration for fiscal year 1986 is inconsistent with the estimates of need and medical requirements to meet the needs projected in the VA's own report. The VA budget and budgets for other health and medical functions of the Federal Government proposed for next year and beyond raise serious questions about the capacity of this Nation to meet both the needs of the veterans and of other citizens as they reach the time of life of increasing medical needs. Further, there is alarming evidence of a reluctance to address in a comprehensive way the gaps and overlaps in acute and long-term care available and planned for aging people.

A second topic will be the assessment of the size of the aging population for purposes of resources distribution. For example, to what extent are veterans counted twice, once for VA benefits and once for Medicare or other benefits? Or, are they not counted at all? Letters sent as part of the preparation for this hearing included questions about the numbers of veterans who would be affected by two proposals which are anticipated from the administration and about the shifts in costs or beneficiaries which might result. There appears to be a general lack of coordination within the Federal establishment to address questions of this type. More disturbing is the apparent lack of a comprehensive strategy to acquire and analyze information which is necessary to the formulation of good public policy. It is my understanding that the major source of information in the Federal Government which can be used to describe and predict the utilization of medical services and their costs and the characteristics of the people who received medical services is based on a 1977 survey. I know that the VA has produced information about the insurance coverage of veterans which is at variance with the 1977 survey data. This is probably due to methodology differences, and yet, I understand that the VA and other agencies are very reluctant to support another such survey of the current situation and to resolve the methodological differences.

In preparation for this hearing, joint letters were sent by Chairman Roybal and me requesting the numbers on which administration estimates of the effects of proposals on health care elibibility are based. These letters were sent to the Department of Health and Human Services, the Veterans Administration, and the Congressional Budget Office. I would like to insert copies of the letters into the record at this point. Information requested in the letters was about resource distribution and the counting of veterans with specific reference to policy proposals of the administration. One proposal is to change the eligibility criteria for non-service-connected veterans health care based on means tests. Another proposal is to recover costs of VA-delivered care from third party payors. It seems more than reasonable that these agencies should be able to present written or oral testimony regarding the real effects on the distribution of our national resource due to changes in eligibility. Yet, no answers to our letters have been received.

The third topic is the experiences veterans encounter as they seek services. We are particularly interested in these experiences in order to assess both the planning and implementation of the policies we in the Congress enact and the Federal agencies administer.

We will hear testimony from Dr. Donald Custis and Dr. John Rowe regarding their projections of the array of services for aging and the relationship between the VA and other providers of these services. We will hear the first hand experiences of those who help aging veterans negotiate the fragmented system of care sometimes available—service officers from veterans service organizations and a social worker from the private sector.

Thoughout our hearing, the factors that make this phenomenon of aging so troublesome will come up repeatedly.

The rapidity of the growth of the aging veteran and, not too far behind, the aging American. The speed of this growth, of course, is exceeding the biomedical knowledge of the aging processes. Even as this knowledge base grows, the variety of ways to care for your aging citizenry and the chronic diseases which often affect them also grows and may require dramatic changes in the ways medical and other services are organized and delivered. All of this is within a time-frame that is all too short.

The phenomenon of aging operating simultaneously at the national, or aggregate, level as well as at the individual level. Policies to direct eligibility for medical care which may seem sound with regard to organizing the entire Federal sector, for example, may have unintended consequences for elderly persons and their families when it comes time to meet multiple needs which characterize aging.

The cost of the programs which have grows to cope with the aging phenomenon are very high. It has become necessary to take into account very early in policymaking the financial obligations incurred when structuring medical services. The Federal deficits are frightening, indeed, and cannot be ignored in addressing national needs.

The decisions about aging affect all family members. This is not an area of public policy which can long remain analytically distinct from the emotional bonds of ourselves to our parents and our children.

We in the Congress and the executive branch have the responsibility and the opportunity to face this phenomenon of aging. It is, indeed, our decision whether to fill a golden pond for our aging citizens or to leave a dry hole. We will talk about it today in a national way, veteran and nonveteran together, and about the dilemmas it presents to health and other professions, to private organizations, and to State, local and the Federal Governments. Surely, the range of individuals, organizations and entities involved in this phenomenon create opportunities for sharing the multiple responsibilities associated with aging. I hope this hearing will start an awareness of the opportunities for sharing.

Before recognizing my colleagues, I want to insert in the hearing record a letter from Office of Legislation in the Department of Health and Human Services declining our requrest for a repesentative from the Department to testify today. That letter reflects a misunderstanding of the purpose of the hearing which was explained in the letter of invitation to the Department. The purpose was stated as an examination of problems and opportunties that result from the interaction of health policies for older veteran with those for the elderly at large. I am dismayed at this further evidence of an unwillingness of the administration to comprehensively address the health care needs of aging citizens. Additional, on March 14th, Chairman Roybal and I requested that the VA, as well as the Deparment of Health and Human Services' Health Care Financing Administration and the Congressional

Budget Office, provide detailed analytic data concerning the means test and third party reimbursement. Our March 14th letter stated, "It is expected that the VA and HCFA will share data relevant to the request internally and with the Congressional Budget Office." If there are no objections, I would like to include in the hearing record a copy of the administrator's response which I received yesterday at approximately 11:30 a.m., which states that, "you urged us to coordinate the preparation of this impact analysis with the Health Care Financing Administration and the Congressional Budget Office. While we have initiated the interagency coordination you requested, I am disappointed to report that the complex analysis you had hoped could be furnished to the committees by April 12, remains incomplete." We did not request coordination—only sharing of data. It remains a mystery to me how the administration can propose such major changes in eligibility when they do not have relevant data to make such proposals.

The chairman of the Select Committee on Aging, the Honorable Edward Roybal, has been detained at another hearing and will join us later. I will now recognize the ranking minority members of the Subcommittee on Hospitals and Health Care, who is also a member of the Select Committee on Aging, the Honorable John Paul Hammerschmidt for any remarks he may with to make. John Paul.

Our first witnesses this morning consists of a panel of veterans service officers from the Disabled American Veterans and the Veterans of Foreign Wars. (Introduce them from the agenda).

House of Representatives,
Select Committee on Aging,
Washington, D.C, March 14, 1985.

Hon. Margaret M. Heckler,
Secretary, Department of Health and Human Services, Washington, DC.

Dear Secretary Heckler: On April 23, 1985, the House Select Committee on Aging and the Subcommittee on Hospitals and Health Care of the House Veterans Affairs Committee will hold a joint hearing in Washington, D.C. on the aging veteran. The purpose of the hearing is to receive testimony on H.R. 505, "The Older Veterans Health Care Amendments of 1985" and to examine problems and opportunities that result from the interaction of policies for older veterans with those for the elderly at large.

In preparation for this hearing, we are requesting that the Health Care Financing Administration prepare a report on the impact of VA eligibility reforms being considered by the Administration on Medicare and Medicaid costs. This report should be transmitted to us in writing by April 12, 1985 and presented as part of testimony at the April 23 hearing. Similar requests are being made of the Veterans Administration and the Congressional Budget Office.

It is our understanding that the following two proposals for eligibility reform either have been or are under serious consideration by the Administration. Accordingly, these proposals should serve as the basis for HCFA's impact analysis. We have asked the Veterans Administration to inform us if these proposals should be changed to more accurately reflect Administration proposals.

An income-based proposal under which the eligibility level for non-service-connected veterans would be double the pension income standard; eligibility determination would be based both on income and prior out-of-pocket contributions to medical expenses; private third party payers would be charged regardless of the insured veteran's income level; and veterans would not be required to seek care through Medicare or Medicaid before becoming eligible for VA services.

A second proposal under which income and the availability of all third party payers, including Medicare and Medicaid, would be considered in eligibility determinations for non-service-connected veterans. This proposal has two variations. One, with Medicare and Medicaid as first payers for all non-service-connected veterans regardless of income, and a second with Medicare and Medicaid as first payers only for those veterans falling above the income ceiling.

Under both proposals, eligibility for VA services would apply equally to VA direct and contract inpatient, outpatient, and nursing home care and would be based on income and an expected medical expense contribution. Non-service connected veterans with family incomes above double the maximum annual VA pension rate would not be eligible for VA care until out-of-pocket medical expenses exceeded a specified percentage of income above that pension rate, as presented below.

Income interval as percent of double pension rate	*Medical expense contribution as percent of income above ceiling*
100 to 116.7	25
116.8 to 133.3	35
133.4 to 200	50
200.1 to 566.7	75
566.8 and over	90

A detailed analysis of both proposals should demonstrate the impact of each on: (1) the non-service-connected veteran and his/her family's average out-of/pocket-costs; (2) the number of veterans that would be shifted over to Medicare and Medicaid; (3) the administrative and health care costs of Medicare and Medicaid; and (4) Medicare solvency through 1995. Information is also requested on the number of veterans who are current users of both VA medical and Medicare/Medicaid programs.

Estimates for all categories of impact should be projected annually through 1990 for inpatient, outpatient and nursing home services. Data should also be itemized by veteran age (under 65, 65–74, 75 and over) and by category of third party payer, with Medicare and Medicaid listed separately. Recommendations are also requested on appropriate follow-up studies and demonstrations related to the issue of multiple eligibility.

Thank you in advance for your cooperation. It is expected that HCFA and the VA will share data relevant to this request internally and with Congressional Budget Office. If you have any questions, please do not hesitate to contact Nancy Smith of the Aging Committee staff (226–3375) or Jack McDonell of the Veterans Committee staff (225–9154).

Sincerely,

EDWARD R. ROYBAL,
Chairman, Select Committee on Aging.

BOB EDGAR,
Chairman, Committee on Veterans Affairs, Subcommittee on Hospitals and Health.

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC, April 2, 1985.

Hon. MARGARET M. HECKLER,
Secretary, Department of Health and Human Services,
Washington, DC.

DEAR SECRETARY HECKLER: As you were advised on March 14th, the House Select Committee on Aging and the Veterans Affairs Subcommittee on Hospitals and Health Care will hold a joint hearing on aging veterans Tuesday, April 23, 1985 at 9:30 a.m. in Room 334 of the Cannon House Office Building. This hearing will examine problems and opportunities that result from the interaction of health policies for older veterans with those for the elderly at large.

The Committee would appreciate your testimony or that or a representative from the Department of Health and Human Services at this hearing. Specifically we wish to learn the results of the Department's impact analysis of proposed changes in veteran eligibility on Medicare and to learn how the Department, in collaboration with the Veterans Administraiton, is preparing for the increasing numbers of older veterans.

Please indicate the names and titles of the Department's witness and any accompanying staff by close of business on April 17, 1985. In addition, one hundred and fifty copies of the prepared testimony should be provided to the Committee in Room 712, House Office Building Annex 1, by close of business on Friday, April 19, 1985.

I look forward to hearing the testimony of the Department on this critical issue.

Sincerely,

EDWARD R. ROYBAL,
Chairman, House Select Committee on Aging.

Department of Health & Human Services,
Office of the Secretary,
Washington, DC, April 18, 1985.

Hon. **Edward Roybal,**
Chairman, Select Committee on Aging, House of Representatives, Washington, DC.

Dear Mr. Chairman: This is in response to your letter requesting that the Department provide a witness for the joint April 23 House Aging-House Veterans Affairs Subcommittee hearing on health policies for older veterans.

We agree with you that this issue merits careful and serious study, and appreciate your asking the Department to participate in your hearing next week. As staff has advised your office, though, we feel it would be more beneficial for the Veterans Administration to speak for the Administration on veterans health policy at this point; after further study within the Department of this issue, for which the VA has the lead, we would be pleased to testify before your Committee.

In the Interim, though, we will provide a statement for the record and will, of course, discuss in that statement your request that we analyze the impact on Medicare of proposed changes in veterans' health care eligibility.

Again, thank you very much for extending the invitation to particiapte in your hearing.

Sincerely,

Lawrence J. DeNardis,
Acting Assistant Secretary for Legislation.

House of Representatives,
Select Committee on Aging,
Washington, DC, April 19, 1985.

Hon. **Margaret M. Heckler,**
Secretary, Department of Health and Human Services,
Washington, DC.

Dear Secretary Heckler: On March 14, 1985 and again on April 2, 1985 we requested that the Department of Health and Human Services present testimony before a joint hearing of our Committees on aging veterans. We understand from Mr. DeNardis' response today that the Department has decided not to honor this request.

Contrary to the reasons given for this decision, the hearing will address issues of significance not only to veterans, but to all older Americans. As indicated previously, "this hearing will examine problems and opportunities that result from the interaction of health policies for older veterans with those for the elderly at large." To engage in any meaningful dialogue on this topic requires that both the VA and non-VA public sectors be present.

We fully agree that the Veterans Administration is the appropriate spokesperson for the Administration on veterans issues. However, in the Department's absence, who will represent the Administration on Medicare, Medicaid, Older Americans Act, and other programs under its purview? The fact that 85% of all U.S. veterans will never be seen by the VA, that veterans and their spouses are directly affected by programs of both agencies, and that the policies of these agencies interact in a way that impacts the beneficiaries of both, makes the issue of growing numbers of older veterans an intergovernmental responsibility.

As Chairmen of the sponsoring Committees, we again ask that the Department be represented and provide testimony at the April 23rd hearing on this issue of immediate importance.

We trust that the Department will favorably reconsider its decision and ask that you inform us accordingly by noon Monday, April 22.

Edward R. Roybal,
Chairman, Select Committee on Aging.

Bob Edgar,
Chairman, Committee on Veterans' Affairs,
Subcommittee on Hospitals and Health.

House of Representatives,
Committee on Veterans' Affairs,
Subcommittee on Hospitals and Health Care,
Washington, DC, March 27, 1985.

Hon. Harry Walters,
Administrator of Veterans' Affairs, Veterans' Administration,
Washington, DC.

Dear Mr. Administrator: As you were advised on March 14th, the Subcommittee on Hospitals and Health Care will hold a joint hearing with the Select Committee on Aging on Tuesday, April 23, 1985 at 9:30 a.m. in Room 334 of the Cannon House Office Building. The subject of this hearing is to receive testimony on the issue of the aging veteran and problems and opportunities that result from the interaction of policies for older veterans with policies of other Federal agencies. The Subcommittee would appreciate knowing the names and titles of the Veterans' Administration witnesses at this hearing by close of business on April 17, 1985. One hundred fifty copies of the prepared testimony should be delivered to Room 335, Cannon House Office Building, by close of business on Friday, April 19, 1985.

On Thursday, April 25, 1985 the Subcommittee on Hospitals and Health Care will hold a hearing at 9:30 a.m. in Room 334 of the Cannon House Office Building. The subject of the hearing is H.R. 505, the Older Veterans' Health Care Amendments of 1985. The Subcommittee requests the testimony of Dr. John Mather, Assistant Chief Medical Director for Geriatrics and Extended Care. The Subcommittee would appreciate confirmation of his appearance, as well as the names and titles of those accompanying him, by close of business on April 17, 1985. One hundred fifty copies of the prepared testimony should be provided to Mrs. Arlene Burnett in Room 335, Cannon House Office Building, by close of business on Tuesday, April 23, 1985.

Sincerely,

Bob Edgar,
Chairman, Subcommittee on Hospitals and Health Care.

Veterans Administration,
Office of the Administrator of Veterans Affairs,
Washington, DC, April 18, 1985.
Hon. Bob Edgar,

Hon. Bob Edgar,
Chairman, Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, House of Representatives, Washington, DC.

Dear Mr. Chairman: Thank you for the invitation extended jointly by Congressman Edward R. Roybal and yourself to appear at the joint hearing of the Subcommittee on Hospitals and Health Care and the Select Committee on Aging on April 23, 1985. It is our understanding that this hearing is intended to consider the issue of the aging veteran and problems and opportunities resulting from the interaction of VA policies for older veterans with policies of other Federal agencies.

I am pleased to inform you that John W. Ditzler, M.D., VA's Chief Medical Director will testify for the Agency. Dr. Ditzler will be accompanied by John Mather, M.D. our Assistant Chief Medical Director for Geriatrics and Extended Care; Marjorie Quandt, the Assistant Chief Medical Director for Administration; and by James Gregg, Deputy Director, Program Analysis and Development.

In your March 14, 1985, letter of invitation, you inquired about VA's legislative proposal to revise medical eligibility and the impact that such a proposal is expected to have on those affected. In your letter, you asked for detailed analytic data concerning two proposals for revising medical eligibility which you understand to be or to have been under serious consideration by the Administration. You urged us to coordinate the preparation of this impact analysis with the Health Care Financing Administration and the Congressional Budget Office.

While we have initiated the interagency coordination you requested, I am disappointed to report that the complex analysis you had hoped could be furnished to the Committees by April 12, remains incomplete. I regret the confusion that has surrounded the question of revising VA medical eligibility. However, this hearing should provide a helpful opportunity to clarify the nature of our proposal.

We will attempt to furnish one hundred and fifty copies of our prepared statement by April 19, and will advise your staff if the testimony cannot be provided within this time period. A similar letter has been sent to Congressman Edward R. Roybal, Chairman, Select Committee on Aging.

Sincerely,

HARRY N. WALTERS, *Administrator.*

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HUMAN SERVICES,
Washington, DC, October 30, 1984.

Hon. HARRY N. WALTERS,
Administrator, Veterans Administration,
Washington, DC.

DEAR ADMINISTRATOR WALTERS: As a follow-up to my Subcommittee's recent field hearing on "Older Veterans: Growing Numbers and Changing Needs" and your agency's report entitled "Caring for the Older Veteran," I am requesting your assistance in developing further some of the ideas for linkages among VA and non-VA services, data sharing, resource assessment and advocacy for elderly veterans.

It is important for all older Americans, but particularly for elderly veterans, that we begin now to explore the available acute and long-term care resources of the public and private sectors, and plan for the development of additional resources to meet the impending needs of those populations. I am particularly interested in opportunities for coordinating the Older Americans Act programs with VA aging programs. Dr. Mather, the Assistant Chief Medical Director for Geriatrics and Extended Care, was most cooperative and helpful at our hearing regarding this issue: however, I have some additional issues and concerns which I have outlined below for your consideration and response.

I. LINKAGES AMONG VA AND NON-VA SERVICES

One goal delineated in the VA report is ". . . to coordinate and integrate VA programs for the aging veteran with similar programs in the community at large." I am very interested in the achievement of this laudable goal. In particular, I would like to know your ideas about how the aging network can cooperate in the implementation and successful operation of "community collaboration offices," joint information and referral, case management, and the like. Furthermore, please let me know your thoughts on how to foster better collaboration on the national level between the Administration on Aging and the VA.

II. DATA SHARING

During our recent hearing it became evident that very little is known about the number of veterans currently served through the Older American's Act and other non-VA programs. It is imperative that appropriate data resources be developed to identify older individuals needing services and available resources. However, resources should not be expended to develop new data bases if information that already exists has not been fully shared among appropriate organizations. I would like to know your ideas on how the VA can coordinate the development of new data sources with non-VA organizations to prevent data duplication.

III. RESOURCE ASSESSMENT

Another concern of mine regarding information is the need to adequately assess available and future resources to provide for the continuum of older persons needs. The VA report assumes availability of non-VA resources to meet some of the long-term care needs of the older veteran population. Non-VA resources for community-based, non-institutional long-term care services are significantly fewer than those for institutional services and both institutional and non-institutional services will be taxed with the increasing demand from the non-veteran, older population as well as older veterans. My question is how the aging network and the VA can work together to properly assess available public and private, institutional and non-institutional long-term care resources and project the future resource needs of VA and other older populations.

IV. ADVOCACY FOR ELDERLY VETERANS

A long standing concern of mine is the extent to which the federal bureaucracy gives adequate attention to the complex issues of the aging. As the VA expands its programs for older veterans, new issues previously not areas of concern for the VA will have to be addressed such as elder abuse and training and retraining for the elderly. I would like to know your thoughts on how the aging network can cooperate with the VA in order to plan for these special problems and needs of the aged.

The VA, with your leadership, has begun to face up to and plan for one of this Nation's major challenges. I commend you for spearheading the development of the geriatric report and request your assistance in determining ways in which the aging network and the VA can cooperate in meeting the challenge.

I would appreciate a response at your earliest convenience.

With kindest personal regards, I am,

Sincerely,

MARIO BIAGGI, *Chairman.*

VETERANS ADMINISTRATION,
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS,
Washington, DC, April 22, 1985

Hon. MARIO BIAGGI,
Chairman, Select Committee on Aging, Subcommittee on Human Services, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: I am pleased to respond to your inquiry concerning the growing numbers and changing needs of older veterans and the four specific issues you raised. The Chief Medical Director and his staff have completed their review of these issues, and I am now able to address your concerns in a comprehensive manner.

As a point of departure, I believe it is important to recognize the statutory authority which governs the Veterans Administration as it affects older veterans. In general, the Veterans Administration provides a broad spectrum of income maintenance and support programs. From the Department of Veterans Benefits, compensation and pensions provide necessary income support and are augmented by various other benefits such as VA mortgages, occupational programs, and adaptive housing and automobile allowances.

In the Department of Medicine and Surgery we are able to provide a comprehensive array of health care services to eligible veterans, ranging from acute medical care to adult day health care. At the same time, the Department does not have authority to provide a broad spectrum of health related or social welfare services. For example, the Department may not provide, directly or through contract, chore services or meal shopping and preparation.

The Department of Medicine and Surgery relies on two sources for health related/social support services. First, certain veterans are eligible for aid and attendance or housebound rates from the VA's service-connected compensation and the nonservice-connected pension program. These higher rates reflect an individual's disabilities, which require additional assistance in daily activities, and assist the individual veteran in purchasing needed and desired services. The second source of assistance for the older veteran in need of supportive services is the veteran's own community. The package of community-based programs, funded through Federal, state, local, and private agencies, is available to the frail elderly veteran as a citizen, although comprehensive community services are not universal. I will discuss the topic of "linkages" of VA and non-VA services in more detail later in this letter.

While the VA must operate within the context of its statutory authority, I want to emphasize the Agency's concern for and study of the role and future development of community-based health care and health related services. I believe this remains a critical area of exploration, especially as these community services affect the quality of life of the elderly and the efficient and effective utilization of institutional health care. The Agency's own report, "Caring for the Aging Veteran," and Harvard University's "Older Veterans: Linking VA and Community Resources" contain numerous ideas and recommendations on future approaches to community based care and its systematic development and coordination. These concepts are receiving continued and intense review within the Agency.

Having presented this background, I will proceed to address your specific concerns.

I. LINKAGES AMONG VA AND NON-VA SERVICES

At the medical centers, the VA works with community organizations on several levels: academic, administrative, professional/technical, and service delivery. The service delivery component, of particular interest here, is primarily intended to refer veterans to community health and social services following VA hospitalization.

Service delivery components of VA/community relationships are primarily, though not exclusively, part of the discharge planning process to assure that veterans receive health care and social services to support their post-hospital adjustment and delay or eliminate the need for reinstitutionalization. This ongoing patient based referral function was reinforced and formalized in 1975 when the VA signed the Working Agreement for the Consortium on Information and Referral Services to Older People, as part of the Older Americans Act Comprehensive Amendments of 1973. This Agreement was updated and revised in April 1983 (Enclosure A).

Section 106 of the recently enacted Public Law 98-528 reinforces the process of effective coordination in service delivery. Moreover, the Information and Referral Agreement seeks to raise the concept of VA/community interaction from a patient specific to a systematic level, coordinating VA benefits and services in the aggregate with state and local, public and private community agencies and sharing information about benefits and services with those agencies.

Our assessment of the situation is that at the patient level we have been largely successful in linking community based services with the needs of the patient, but that additional study and new strategies will be necessary to fully coordinate services at a system level.

Nationally, the Department of Medicine and Surgery is working with the Administration on Aging (AoA) to develop an agreement for jointly sponsored demonstration projects for VA/AoA collaboration. These projects would focus on (1) providing specific (in some cases newly developed) services to caregivers and patients with Alzheimer's disease; (2) developing new, community based treatment alternatives; (3) developing effective models of collaborative case management to produce optimal use of community resources; and (4) developing collaborative education programs for the clinical staffs of the VA system and the aging network. Further action on these initiatives awaits the naming of a new Commissioner on Aging.

II. DATE SHARING

The VA is participating in a number of projects which should improve information systems on the elderly population and the utilization of long term care services. These initiatives are designed to avoid any duplication of effort.

First, as an outcome of the joint American Health Planning Association/VA Conference in September 1984, participants meeting in state groups set in motion the development of joint data systems among all members of the planning/service delivery community. Follow-up questionnaires of the participants show continued movement in that direction.

Second, the VA is one of five Federal agencies which is sponsoring a National Academy of Sciences project on Statistics for an Aging Population. The project will produce two major products over the next two years: a set of eight commissioned papers on various aspects of health, aging, and statistics, and a final report containing the panel's recommendations for statistical analyses of major policy issues in the field of aging and health.

At the local level, VA medical centers continue to participate in the development of, and actively use, community based resource directories for referral purposes. These directories are often funded by Area Agencies on Aging or the United Way. Additional efforts by all interested parties in this area will be necessary to better understand the aging patient population, their needs and the appropriate utilization of services.

III. RESOURCE ASSESSMENT

I share your concern about the future availability of institutional and non-institutional health and social services. Recently, we commissioned the Institute for Health Planning (IHP) in Madison, Wisconsin, to study the potential availability of non-Federal acute care and nursing home resources which might supplement VA resources during the 1990s. The summary of the IHP's analysis (Enclosure B) is not particularly reassuring, especially for nursing home care. The forthcoming National Nursing Home Survey to be conducted by the National Center for Health Statistics may provide further insight into the magnitude of this problem.

The VA is not in a position to evaluate the future availability of noninstitutional services at this time because the current data base is largely decentralized and fragmented.

One program where the VA can, to a limited extent, support resource development is adult day health care, under a provision of P.L. 98-160 which allows "in kind" assistance within a contractual setting. The assistance may only be provided, however, if the VA is reimbursed for the full cost of this assistance. The VA remains committed to the exchange of information about benefits and services and to the provision of technical assistance to community agencies as provided through P.L. 98-528 and the Information and Referral Program referenced earlier.

IV. ADVOCACY FOR ELDERLY VETERANS

The specific issues that you have raised regarding the training of elderly workers and the abuse of the elderly remain unresolved. At the local level, VA employees have been active in addressing these concerns as private citizens involved in their communities. It is my belief that as the Agency develops its systematic strategies toward community based services, we will be in a better position to assist local communities.

In summary, I know that the VA will continue to contribute its leadership and its expertise toward the care of the elderly.

I appreciate your interest and I assure you that we will continue to work on the issues that confront elderly veterns and will continue to share our experience with all groups that help older Americans lead a better life.

Sincerely,

Harry N. Walters, *Administrator.*

Enclosures.

Enclosure A.

ATTACHMENT A

A Working Agreement for the Consortium on Information and Referral Services for Older People

I. BACKGROUND

In May 1975, a Working Agreement on Information and Referral Services for Older People was negotiated among fifteen Federal Departments and agencies and an Interdepartmental Task Force, on Information and Referral established. The Task Force, in response to a Federal directive, was expected to (a) assess the Federal information and referral resources that exist and (b) develop a plan of action designed to improve and coordinate these resources. As a result, the Federal agencies agreed to work in concert to achieve the following objectives.

(1) Improve the information and referral activities of Federal Departments and agencies in order to maximize the efforts of the Federal Government in responding to the needs of older people.

(2) Improve the activities of Federal Departments and agencies to facilitate actions that impact directly on the improvement and coordination of information and referral services at the State, area and community levels.

(3) Monitor and evaluate the progress of Federal agencies' responsiveness to the information and referral needs of older people.

Implementation of the Agreement has contributed to the significant progress in the delivery of information and referral services to older Americans, from the Federal to the local level. Knowledge has been gained about the processes and technologies that are being used to enhance Information and Referral (I&R) services which was transmitted to program administrators and personnel. Task Force efforts have paved the way to improved cooperation between governmental and non-governmental agencies and organizations. Sepcific Task Force accomplishments are:

Publication of an I&R Guide which sets forth baseline criteria for I&R services to be judged adequate regardless of organization and scope. The Guide has been distributed to users nationwide.

Development of a strategy for a local-level pilot I&R workshop with potential for nationwide implementation. Two Statewide I&R workshops were conducted—one in North Carolina and the other in Indiana. Results of the workshop have been described and disseminated to States and Area Agencies on Aging.

Annual reports which describe yearly projects of the Task Force and the I&R actions of member agencies.

Recent Federal legislative changes and agency reorganizations have resulted in the loss of several agencies which were party to the I&R Working Agreement. As a result, a new agreement and coalition of agencies is necessary to continue collaborative efforts to promote and to improve I&R Service delivery—specifically to strengthen I&R network systems as a more efficient and cost effective means of providing services. A Consortium of Federal agencies and private sector national organizations with a serious interest and/or investment in I&R is being undertaken as a support to States, Area Agencies on Aging and local communities in furthering the development and operation of comprehensive coordinated I&R service systems.

An I&R system is defined as the structure and process for linking people in need with appropriate resources within a given geographic service area. Critical to the system is the cooperative participation of all entities performing the specific I&R functions. The I&R system must involve both horizontal relations (among I&R providers at the same level) and vertical relationships (between I&R providers at different levels). The effectiveness or capacity of an I&R system will be determined by the extent and quality of these relationships.

II. PURPOSE

Presently a large part of the Federal role is directed at the issues of efficiency and effectiveness in the delivery of human services. There is renewed interest at all levels of government in ensuring that the resources available are being applied in order to obtain the most benefit.

The focus of the Administration is upon issues that cross cut human services such as systems development, resource allocation, measuring quality and cost-effectiveness, and greater private sector involvement.

It is expected that States, Area Agencies and community programs will achieve greatest efficiencies in their operations to seek confirmation that the services and benefits are being directed to programs which are indeed effective. Major change and innovation in social services is likely with a growing trend for expanded private sector involvement and greater integration of local services.

Information and Referral networking is a vital element in meeting the challenge of today's emphasis on systems development, services integration, and responsive and cost-effective service delivery. Within the context of the original objectives of the Interdepartmental Task Force—to improve services and respond to the needs of the older people—the purpose of this agreement, is to stimulate the development and strengthen I&R network systems through cooperative and coordinated efforts of a consortium of Federal and public agencies, selected national voluntary organizations and the private sector.

III. IMPLEMENTATION STRATEGIES

The Administration is committed to a social service philosophy which holds that when social services are needed, they are best defined and administered at the community level where the most accurate information is available about the nature and extent of the problems and the appropriateness of a variety of resources or solutions. Access to appropriate resources is a continuing fundamental issue facing the service delivery system. Pertinent to the issue of access is the use of I&R and consumer information to enable persons in need to learn of services.

The Working Agreement on Information and Referral Services for Older People will provide a tool to assist States and community agencies in the development of cooperative relationships necessary for effective use of available resources and for coordination of I&R planning and service delivery activities.

Statement of goal:

To promote I&R network systems through cooperative and coordinated efforts of the I&R Consortium. To accomplish this goal, it will be necessary—

1. To provide dialogue and exchange of information regarding I&R and consumer information systems among selected national organizations and Federal agencies, and the private sector.
2. To identify and encourage dissemination of "best practice" I&R information systems.
3. To encourage the development of workshops and support participation in national, regional, and local conferences specifically focused upon developing I&R network systems.
4. To cooperate in the design and implementation of special projects which enhance the development of I&R systems.
5. To promote the dissemination and utilization of I&R systems standards.

In support of the stated objectives each agency will:

1. provide a representative to actively participate in the functions of the Consortium including—attending monthly meetings, reporting agency I&R activities to the Consortium, and ensuring the fulfillment of action steps of that respective agency;
2. identify and disseminate available information to its constituency using existing channels of communication such as newsletters, interorganizational memorandum(a), conferences, and workshops; and

3. support the participation in special projects as determined by the Consortium to further the development and operation of I&R systems.

The Information and Referral Consortium action steps are defined more specifically as follows:

The Administration on Aging will:

Provide the Chairman for the Consortium and staff assistance as appropriate.

Provide direction and technical assistance material to AoA Regional Offices to support staff efforts in mobilizing the interest and cooperation of State and Area Agencies on Aging in the development locally of I&R systems.

Transmit to the Network on Aging the concept of an I&R systems approach to the human service delivery network and distribute the AIRS/UWA Joint Standards for I&R systems.

Encourage State and Area Agencies and Aging to support and participate in local efforts and to develop and implement I&R systems.

Encourage the Network on Aging staff to attend and participate in national and local conferences which focus upon I&R issues and the latest developments in the field.

Disseminate data pertaining to I&R systems development and "best practice" information and survey the Network for I&R developments.

The U.S. Department of Agriculture (USDA), Office of Rural Development Policy (ORDP) will:

Continue providing a liaison to work with the I&R Consortium in the implementation of its goals and objectives.

Identify "best practice" I&R information systems, if available, from the rural development strategy responses.

Promote outreach for the rural elderly through the Working Group Members of the Rural Development Committee of the Secretary's Policy and Coordination Council, which represents 15 agencies within USDA and the State Food and Agriculture Councils.

The Alliance of Information and Referral Systems, Inc. (AIRS) will:

Provide Consortium members with written fact sheets and membership information about AIRS.

Make available similar information for distribution to state, regional or local affiliates of Consortium members.

Report to the Consortium on programs and activities of AIRS and its members, i.e.:

Conferences and training opportunities

Publications (e.g., newsletters, journals, national director of I&R programs, papers)

Special projects demonstrations

Calls for papers

Through the bi-monthly AIRS newsletter, report to AIRS members on programs and achievements of the Consortium.

Make available to Consortium members and their affiliates the AIRS-United Way of America National Standards for Information and Referral and the AIRS program sel-evaluation tool, when finalized.

Participate in the design and implementation of special projects undertaken by the Consortium to enhance the development of information and referral systems.

The Department of the Army, Office of the Adjutant General, Army Community Services Division, will:

Promote the dissemination and utilization of national information and referral standards DOD-wide.

Conduct a workshop at the 1983 Army Community Service conference regarding information and referral network/systems.

Identify and disseminate "best practice" information and referral systems through regulations, handbooks, newsletters, and workshops.

Disseminate Army Community Service directories and fact sheets regarding information and referral systems among Consortium representatives.

Disseminate Consortium directories and fact sheets regarding information and referral systems among Major Command Army Community Service representatives.

The Clearinghouse on the Handicapped will:

Through the bi-monthly newsletter, "Programs for the Handicapped", and other publications, provide current information on federal programs, legislation, funding, and publications.

Link providers of services to handicapped individuals (such as independent living centers) with information and referral centers.

Make the availability of the Clearinghouse's "Directory of National Information Sources on Handicapped Conditions and Related Services" known to potential users across the nation. This directory is a major networking tool describing the information services of all major national organizations and agencies serving the disabled population. This publication can also assist in locating information and services for elderly individuals, since resources are listed for many of the conditions which afflict them, e.g. arthritis, diabetes, stroke, and hearing and vision loss. The information contained in the "Directory" is available for on-line searching through Bibliographic Retrieval Services.

The U.S. Department of Education, Center for Education Improvement, Division for Library Programs State and Public Library Services Branch will:

Promote and disseminate information on I&R, especially "Best Practice" projects, to the State Libraries throughout the Country and the Territories, through the use of the Information Memorandum system utilized by the Branch.

Promote the dissemination and utilization of national I&R standards within the framework of the public library systems through coordination with and information dissemination to the State Library Administrative Agencies and their staff specialists.

Coordinate and sponsor major events like "National Consumers Week" April 24-30, 1983. NCW will focus national attention on lifelong consumer education and provide a vehicle for highlighting existing consumer education programs and materials and encourage development or more information programs and materials.

Work cooperatively with Consortium members in developing and implementing special projects which will enhance and improve information and referral services.

Maintain and disseminate to Consortium members resources located throughout the country which can enhance the development of information and referral networks in consumer education and protection, health care and safety.

The National Association for Area Agencies on Aging (N4A) and the National Association for State Units on Aging (NASUA) will:

Assist in the exchange of information regarding information systems as appropriate to the Network of States and Area Agencies on Aging.

Assist in identifying "best practice" examples of effective and efficient I&R information systems utilizing information from the Data Base as well as through individual contacts.

Include "practice" examples of innovative and cost-effective I&R systems in the Point of Delivery.

Invite the Consortium to respond to a call for a session to present a workshop on I&R systems to the 1983 Annual Conference to be held in Washington, D.C. in July.

Disseminate I&R Standards to the Network through the Point of Delivery as appropriate.

The National Council on the Aging will:

Promote the dissemination and utilization of national I&R standards.

Promote workshops at NCOA Annual Conference regarding—developing, improving and coordinating I&R systems.

Promote dissemination of "best practice" information and I&R systems through NCOA newsletters and professional and technical membership units.

Provide site for meetings on I&R topics at NCOA's new National Center on Aging.

Assist in the planning of special Consortium projects to improve and support development of information and referral systems.

Provide a liaison to work with the Consortium.

The United Way of America will:

Provide information to the Consortium regarding the networking and program activities of United Way sponsored Information and Referral Services.

Distribute to local United Way I&Rs networking and program information that is provided by Consortium members. This will be accomplished through the use of standard United Way of America communication channels.

A. National Academy for Voluntarism—I&R Roundtable
B. United Way of America Publications and Newsletters
C. Loan Folders
D. Regional and National Conferences
E. Informal Channels

Identify and make available to Consortium members and their affiliates, existing United Way of America resources that can enhance the development of I&R networks.

A. Loan Folders
B. Information and Referral Papers

1. Developing Information and Referral Systems: A Process of Community Organizing

2. Computerizing Information and Referral Services

Present and make available to Consortium, AIRS-United Way of America National Standards for Information and Referral.

Work cooperatively with Consortium members in developing and implementing special projects which enhance and improve I&R networks.

The Veterans Administration (VA)—through the Department of Medicine and Surgery's Central Office, Medical Districts and Medical Care facilities and the Department of Veterans Benefits Central and Regionl Office will:

Develop liaisons with State, Area and Community agencies to:

A. Distribute full information to these agencies to assist aging veterans, their dependents and beneficiaries in obtaining all benefits and services to which they may be entitled under laws administered by the Veterans Administration.

B. Inform State, Area and Community agencies of the needs of aging veterans which are not being met because of ineligibility for or nonexistence of benefits and services under laws administered by the Veterans Administration.

C. Assist in the development of and utilize a system of information and referral services with these agencies.

Share specific technical knowledge in the planning, development and operation of services for the aging.

Provide consultation and technical assistance to State, Area and Community agencies providing benefits and services to aging beneficiaries of the Veterans Administration.

Lennie-Marie P. Tolliver, Ph.D., Commissioner, Administration on Aging, Department of Health & Human Services. March 9, 1983.

Jeanne Diana, Ph.D., President, Alliance of Information & Referral systems, Inc. (AIRS). March 18, 1983.

Willard Phillips, Jr., Director, Office of Rural Development Policy, U.S. Department of Agriculture. March 24, 1983.

Major General Robert M. Joyce, U.S. Department of Army. April 4, 1983.

Helga Roth, Ph.D., Chief, Clearinghouse on the Handicapped, U.S. Department of Education. March 18, 1983.

Donald J. Senese, Assistant Secretary for Educational Research and Improvement, U.S. Department of Education. May 16, 1983.

June Koch, Ph.D., Deputy Under Secretary for Intergovernmental Relations, Department of Housing and Urban Development. March 23, 1983.

Virginia H. Knauer, Special Assistant to the President and Director, U.S. Office of Consumer Affairs. March 21 1983.

Raymond Mastalish, Executive Director, National Association of Area Agencies on Aging. March 29, 1983.

Daniel H. Quirk, Executive Director, National Association of State Units on Aging. March 17, 1983.

Jack Ossofsky, Executive Director, National Council on the Aging. May 18, 1983.

Sheila B. Plank, Vice President, Services Outreach Division, United Way of America. March 21, 1983.

Harry N. Walters, Administrator of Veterans Affairs, Veterans Administration. May 5, 1983.

Herbert Pardes, M.D., Director, National Institute of Mental Health. April 14, 1983.

POTENTIAL FOR RELIANCE ON COMMUNITY HOSPITAL AND NURSING HOME CARE CAPACITY TO MEET VETERANS' HEALTH CARE NEEDS

CONTENTS

I. Background.
II. Tentative conclusions.
III. Basis for conclusions.
IV. Possible private-sector actions and their impact on the VA.

I. BACKGROUND

The DM&S report, "Caring for the Older Veteran" presented several options for dealing with the increased demand for acute and long term inpatient care which accompanies the aging of the veteran population. Among the options in both cases were strategies which are dependent on availability of private sector beds [1] to meet some of the needs of older veterans. Congressman Montgomery asked "should we place heavy reliance on private-sector beds when . . . there has been no study as to whether those beds will indeed be available fcr VA use?"

Unfortunately, there is little systematic knowledge about this issue. The projections which do exist concerning bed availability in each state vary significantly because of differences in methodologies used, reporting requirements, definitions of what a bed is, and in regulatory aggressiveness from state to state.

Nevertheless, the Institute for Health Planning (IHP) conducted an analysis of the private-sector Hospital acute and long term (Nursing Home Care) bed availability. IHP elected to base its analysis on the content of each state's health plan.

Further, IHP was asked to analyze available state data using VA's current Medical Districts as a base in order to link the analysis with VA data. We have received their report. The conclusions that follow are based on the IHP analysis and the estimates of "need" contained in the Report, "Caring for the Older Veteran," (Aging Report).

II. TENTATIVE CONCLUSIONS

The IHP analysis of private-sector availability of beds represents a step forward in enhancing the understanding of the potential for reliance on the private-sector to supplment the VA in meeting veterans' health care needs. However, while it must be considered a necessary step, it is not sufficient for drawing final conclusions especially regarding the potential for reliance on the private-sector in a Medical District or a local community. The data need further refinement, analysis and validation to be used in operational planning decisions. Nevertheless, some general observations at a national level of aggregation can be made.

A. Availability of private-sector hospital acute care beds

It is frequently held that sufficient excess capacity exists, and will continue to exist, in the private sector to meet increasing VA needs without expansion of hospital capacity. The limited use of contracted inpatient acute care was envisioned as one option available to the VA in the Aging Report. The VA's Aging Report estimates that the needs of an older population of veterans will require from 116,000 to 246,000 acute beds during the period 1990–2000. Given the VA's current capacity of 86,000 beds, this means that a minimum of 30,000 additional beds will be required, a figure which might climb as high as 160,000. Can the private sector absorb this demand, assuming that a mechanism could be developed for using that capacity while maintaining VA's responsibility for quality care of veterans?

The IHP study indicates that there may be a wide disparity in the probable number of excess beds in the private sector in the decade of the 90's. The larger estimate would occur under a scenaric which accounts for the effects on private sector utilization of aging of the population, of increased enrollment in organized medical care systems such as Health Maintenance Organizations, (HMO) and Preferred Provider Organizations (PPO), and of the expected application of diagnosis-related groups (DRG) as the model for reimbursement of medical care costs.

The bed excess is a gross figure, and does not attempt to deal with the capacity reducing effects of hospital failures, consolidations, or changes of mission which might be expected to occur as utilization drops. Conventional wisdom, supported by efforts already underway to reduce excess capacity, suggests that the excess will be much less. States and the industry itself, cannot tolerate the costs of maintaining such excess capacity. Even if a large excess were to be realized, it would not be equally distributed across the country. For example, by the year 2000 in VA Medical District 3, the unadjusted excess could approach 29,000 beds, while in Medical District 25, there could be a deficiency of nearly 2,000 beds. Yet District 25 is one of the areas of most rapid growth in the older veteran population. Thus, empty hospital beds often will not be located where they will be needed for veteran patients.

B. Availability of private-sector long term (nursing home) beds

The IHP studies reveal a very different picture when nursing home bed projections within State Plans are considered. Potential does not appear to exist for reliance on the private-sector for nursing home care beds beyond current levels. The private-sector will have difficulty meeting the nursing home needs of the U.S. population, even without caring for an increased number of aged veterans. The larger numbers have a substantial effect on the need for VA-owned or VA-contracted nursing home care. The estimates in the Aging Report range from 60,000 to 120,000 NHC beds required in the 90's to accomodate the veterans needs. Even if all of the VA NHC beds desired by the Medical Districts are funded and built (about 12,000), veterans will still require from 15,000 to 80,000 more bed spaces to be built and operated, or contracted by the VA. Again, can the private sector provide a part of the additional capacity needed? Even if a major building program is embarked on to accomodate private-sector needs there is little likelihood that the private-sector can be relied upon to provide the additional capacity to help the VA accomodate the veteran need for nursing home care.

---

[1] While Congressman Montgomery and the text of this report refer to "private-sector" beds, a more precise term for the analysis in this report is "non-federal" facilities.

III. BASES FOR THE CONCLUSIONS

Below the highlights of the IHP analysis which indicate the factors they considered in determining potential surpluses in the nonfederal sector.

A. Hospital acute care

Adjustments were made in the supply of hospital beds reported by the state health planning agencies to determine the future need for beds to reflect three factors. These were:

1. The anticipated change in 65+ population and its impact on utilization. Increase in the number of elderly persons causes a greater need.
2. The anticipated impact of the growth in enrollments in Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's). Increases in enrollment reduce the need for beds.
3. The anticipated impact of cost reimbursement based on Diagnosis Related Groupings (DRG's). The greater the application of DRG's, the greater the impact on shortening length of stay, thereby, reducing the beds needed.

B. Long term (nursing home) care

As in the case of the hospital program, adjustments were made for:

1. Growth in the elderly population (75+), i.e. greater the increase, the greater the need.
2. The impact of DRG's, resulting in a 3% increase in the use of NHC.

Additionally, the availability of alternatives to NHC and the growth of Social Health Maintenance Organizations (SHMO's) were considered. The anticipated effects of these factors would be a reduction in use by 6% to 20% for the 1990's, as compared with what would otherwise be necessary.

IV. POSSIBLE PRIVATE-SECTOR ACTIONS AND THEIR IMPACT ON THE VA

A variety of actions could be taken by the non-federal sector to deal with the future need for hospital and long term care. These could range from virtually no action to influence bed capacity to a very aggressive approach. Responses are likely to vary considerably from state to state. Listed below are some possible actions and their probable effect on the degree to which the VA can rely on the private-sector to help meet the veterans' needs. The extent to which any of these actions are taken will depend on many factors including financial incentives, and the Federal Government's attitudes towards planning and its role in health care financing.

Action by private-sector	Impact on VA
A. Hospitals:	
1. Close surplus beds	1. Eliminates potential for reliance.
2. Convert unused hospital beds to NHC beds (could potentially eliminate some of the NHC deficit.).	2. Eliminates potential for reliance.
3. Continue to maintain unoccupied hospital beds	3. Provides potential additional capacity for veterans and offers the VA opportunities for relying on the private-sector.
B. Nursing Homes:	
1. Ignore the deficit	1. Eliminates potential for reliance.
2. Use surplus hospital beds to meet NHC deficit	2. Some potential may exist if there is a greater hospital bed surplus than NHC deficits in the private-sector.
3. Build more NHC capacity	3. Potential for reliance on private-sector beds exists for the VA if the private-sector embarks on an aggressive building program.

In summary, two of the above three theoretical courses of action regarding the supply of hospital beds in the non-Federal sector would tend to reduce the number of surplus beds below the high estimate. The third course of action, i.e., involving continued maintenance of surplus hospital beds until future years when the VA might need them, seems unlikely to occur on a significant scale.

Of the theoretical courses of action affecting nursing home bed availability, the first—ignore the deficit—may not be likely in view of the growing need, but resources and incentives still must be identified to stimulate an increased supply. The second course, to convert surplus hospital beds, seems a probable vehicle by which many institutions will be able to improve their balance of acute and long term care, with an as yet undetermined effect on the capacity of both programs. Finally, building new nursing home capacity seems an important component of any future strategy to assure the needed supply.

STATEMENT OF ALBERT L. AVILES, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: It is indeed a pleasure for me to appear before you today to present testimony on the issue of delivery of services to veterans from the Veterans Administration and Non-Veterans Administration Community for long-term non-acute care.

As a National Service Officer for the Disabled American Veterans in Los Angeles, I frequently work with veterans or their families needing assistance in obtaining medical care from the Veterans Administration. The type of care requested ranges from Outpatient Care, Hospitalization, Nursing Home Placement and Domicilary care. The reason they seek treatment from the Veterans Administration is principally because they have been under the impression the Veterans Administration is there to help them. It is true the Veterans Administration's policy is to provide a full spectrum of medical care to eligible veterans. Unfortunately the VA budget does not permit total care for all veterans.

A key problem faced by older veterans in obtaining care from the Veterans Administration is initially meeting the eligibility requirements and the availability of service. Many of the older veterans population have conditions which require care, but whose disabilities placed them in the lowest category of priority groups. For example, a veteran seeking admission to a Veterans Administration nursing unit those disabilities are deemed not service-connected and he has not been hospitalized by the VA and does not qualify for placement under a VA nursing home care contract is placed in the lowest of six priority categories. More and more veterans seeking assistance fall into this category. I recently spoke with the wife of a veteran who was requesting our assistance in obtaining care for her veteran husband. He was a 63 year old World War II combat veteran who required hospitalization in a community hospital in the latter part of 1984. Following his discharge from the community hospital the veteran's condition deteriorated. She took her husband to the nearest VA Facility thinking they would provide care. According to the wife they did not admit the veteran because an eligibility clerk stated he had to be dying before he could be admitted. They were given the excuse he was not service-connected and that there were not enough beds to provide care for him in a VA setting. The VA staff did however, provide assistance to have the veteran admitted into a community nursing home. The veteran received a bill for the ambulance service and after a three month stay, the veteran and his wife could no longer pay their portion of the convalescence hospital bill not covered by Medicare. This realization made him decide to go home and do the best he could under the circumstances. Unfortunately, the veteran was unable to care for himself even with the assistance of his wife who herself was 67 years old and severely disabled on account of a stroke. He has been placed back in a community nursing home which according to his wife "is not fit for human nor animal habitation." She is very bitter with the Veterans Administration and vows never to take him back to the VA because in her words "they just don't care about the older veteran."

This is not an isolated incident. With a growing population of elderly veterans this scenario has become a common occurrence.

The Los Angeles area has the largest concentrations of veterans in the country. There are four Medical Centers, with three nursing home facilities and one domiciliary. The newest of the three nursing homes has accepted its first resident.

In addition to in-house nursing home the Veterans Administration has a contract nursing home care program which utilizes the available services of the community. These community based nursing homes are state approved and must pass an inspection by the Veterans Administration before an eligible veteran maybe placed under VA contract. In order to be placed in a nursing home under this program, a veteran must first be admitted to a Veterans Admininstration hospital and determination must be made that nursing home care is required. If the veteran requires this care due primarily for a service-connected disability, this care may be provided without any time limitation. If need for care is primarily for a non-service-connected disability, nursing home care will be provided for a period not to exceed six months. Veterans seeking admission to a VA hospital solely for nursing home care or rehabilitative services are denied admission. The veteran must be admitted to a VA facility for treatment of an acute illness which requires hospitalization. Once the acute stage passes he can then be placed in a community home. The only exception to this rule is in the case of a veteran who is seeking admission directly into a nursing home care unit for a service-connected disability.

Veterans ineligible for VA nursing care have no choice but to turn to the welfare system for assistance. In most cases, placement is made in a nursing home which falls well below VA Standards. I know from first hand experience many community nursing home care facilities are inadequate. Quality health care in these facilities is virtually non-existent. They lack support services and are often understaffed. I believe the Veterans Administration is best suited to deliver this type of care for the veteran population. They have excellent support services inhanced by Veterans Administration Volunteer Service (VAVS).

To illustrate the difficulties we encounter in having a veteran placed in a nursing home unit of the Veterans Administration let me describe an incident which occurred recently. During a visit by one of my associates to March Air Force Base, he was asked by the chief of nursing services to assist in having a veteran transferred from their hospital to the Veterans Administration nursing home care unit. The veteran had suffered a severe stroke and had multiple problems assessed as stable but required nursing care. It was suggested the attending physician contact the nearest VA Facility with nursing care capacity and seek admittance for the veteran. The VA facility refused to accept his transfer due to a shortage of nursing care beds. Our office then contacted our DAV Department Service Officers at the facility requesting coordination between the Nursing Home Unit and March Air Force Base. The VA facility continued to deny acceptance of the veteran since as they stated there was no bed space available for long-term care nor to handle the particular medical problems involved in his case. As it turned out the veteran was placed in a community nursing home at his own expense. This experience left a very negative impression on the family of the veteran and tarnished the image of the Air Force Facility involved.

Placement in VA contract nuring home for a non-service-connected disability is limited to six months. This causes a significant amount of anxiety for families of veterans. We are continually asked "what will we do after six months?" There are methods of obtaining an extension of this six month contract, however, it is difficult to effectuate. We advise the family of the veteran to attempt to gain readmission into a VA Facility. When readmitted for treatment the veteran can then be discharged to a contract nursing home facility for an additional six months.

Another source of veteran long-term non-acute care is the Veterans Administration Domiciliaries. There are sixteen Domiciliaries in the Nation. Los Angeles is fortunate to have one of these facilities. The domiciliary care is the lowest category of care offered by the Department of Medicine and Surgery.

The domiciliary constitutes one segment of a health continuum without which patients could be forced into higher levels of care or do without regular care. A domiciliary provides to eligible ambulatory veterans continuing medical care in a therapeutic institutional environment, including rehabilitative assistance and other theriapeutic measures. At present the domicilary in Los Angeles has 272 residents. These residents have been admitted to the domiciliary by the medical facility who deemed it was necessary for the veteran to have continuing care but not at the level of a hospital unit. Also, veterans have been referred from outside Community Based Organizations and veterans who have walked in from the street. It is the general feeling of the staff of the Domiciliary in Los Angeles that more and more veterans will seek this type of care especially the World War II veteran population, as they grow older and the community based organizations lose federal funding. In California we also have a unique situation in that many of the community based organizations have lost a considerable amount of funds due to Proposition 13.

One of our major concerns regarding domiciliary care is the income limit which restricts many veterans from being admitted. If a veteran has income of more than $415 per month he is ineligible for domiciliary care. This amount is supposed to be sufficient funds for the veteran to obtain housing and be able to care for himself.

This we believe is a misnomer since it is impossible to live in a healthful adequate setting on $415.

When seeking admission to the Domiciliary the veteran is given a plan to which he must agree, before admission is effectuated. This plan is set up to develop resources of income so the veteran can be discharged into the community. Normally a veteran is admitted for two months. In my view, it is unrealistic to assume that two months is enough time to develop the various benefits either from Social Security or the Veterans Administration to which the individual may be entitled. However, in the Los Angeles Regional Office it normally takes four to five months to obtain a final determination. Social Security is a bit quicker. It still takes a substantial amount of time. If a veteran is ineligible to receive VA pension or Social Security, the only recourse the domiciliary staff has is to refer the veteran to the department of Public Social Service for development of their entitlement to general relief. This means the veteran more than likely will be placed in a substandard hotel on Los Angeles' skid row.

There is also gross understaffing in the Los Angeles Domiliciary Care Unit. In order to accomplish the task of developing sources of income for their residents the Los Angeles domiciliary staff has only two social workers for 272 residents. The situation at the domiciliary will be compounded if indeed the population increases as projected for the future.

My intent today was not to burden this committee with statistical data, but attempt to bring to this esteemed body insight concerning some of the human traumas experienced by our veterans and their families.

Though I've only scratched the surface, I hope my testimony has served to better inform this committee and the American public of some of the difficulties experienced daily by the Disabled American Veterans and similar service organizations nationwide who deal with human problems rather than statistics, which have a tendency to be uncompromising.

STATEMENT OF CHARLES M. MCLEOD, NATIONAL SERVICE OFFICER, DISABLED AMERICAN VETERANS

Mr. Chairman and Distinguished Members of the Subcommittee: On September 8, 1983, I had the distinct pleasure of appearing before the Subcommittee on Hospitals and Health Care at hearings which you conducted in Orlando, Florida. At that time the Committee was receiving testimony dealing with the subject of inpatient and outpatient medical services provided by the Veterans Administration to veterans residing in the VA's southeastern region with particular emphasis being placed on veterans who reside in the southern region of Florida.

Once again, I was very pleased to receive your invitation to appear here today and testify regarding my personal experience in dealing with veterans and their families in obtaining Veterans Administration or non-Veterans Administration services for long term non-acute care.

Mr. Chairman, since my testimony to your Subcommittee in September, 1983, little has changed. In 1983, I was concerned with the VA's inability to meet the increasing medical needs of a migrating, aging veterans' population which was demanding more longer term and more intensive medical treatment.

The Veterans Administration's medical system has been the subject of numerous debates in the State of Florida for a number of years now. The problems facing the veteran in Florida and the VA system itself in the State of Florida are somewhat unique to the nation.

Florida has, for numerous years, enjoyed a rapidly escalating veterans population as more and more veterans migrate from the "Snowbelt" states to the "Sunbelt" states.

As pointed out to the Subcommittee in 1983, the Veterans Administration has not been able to adjust itself to meet the needs of this very mobile veterans population which is not only migrating but is also aging and, in turn, is in need of more long term, non-acute medical care facilities.

Mr. Chairman, during my testimony before the Subcommittee in 1983, I referred to the extremely long waiting times veterans were encountering in obtaining admission to Veterans Administration Domicilaries and Nursing Care Units in the State of Florida. I testified about waiting lists that were as long as two (2) years in some cases. I testified about the need to take action to see that these veterans were given the medical treatment that they were entitled to, that the system be adjusted to obtain more nursing home and domiciliary care beds.

Mr. Chairman, I am very happy to report that things have changed. In fact, as of last week, the Bay Pines VA Medical Center had no one waiting for admission to either its domiciliary or nursing home care units. In fact, only two (2) VA nursing homes in the entire state have waiting lists, one was the Veterans Administration Medical Center in Lake City, Florida which had a waiting list of 24 names and the other was the VA Medical Center in Gainesville, Florida which had a waiting list of only 113.

From the above figures, it appears that veterans in the State of Florida are not in need of nursing care or domiciliary facilities however, the exact opposite is true. The Veterans Administration was able to significantly reduce its waiting list by a simple procedure, they removed individuals from the waiting list who had applied for admission to the domiciliary and/or nursing home care units.

Information I have received indicates that the Veterans Administration now screens applicants for admission to its hospital nursing care units to determine whether or not they have "Rehabilitation potential". If the Screening Committee determines that an individual does have potential for rehabilitation and that this rehabilitation can be accomplished in a time frame of approximately three (3) to four (4) months, then the individual is admitted and provided with the necessary rehabilitation services in order to return him to the outside environment. Long term non-acute medical patients who need simply nursing care and/or domiciliary care are not being admitted to the Veterans Administration nursing homes but are being referred to outside sources. The VA, in some instances, has been placing these individuals in community nursing homes on a six (6) month VA contract, which does meet their immediate need for attention however, upon the expiration of the six (6) month contract, these individuals are forced to "fend for themselves" in obtaining funding to continue their nursing home care.

Other than the need for more consideration for those veterans who are in need of long term non-acute medical care, two other areas have been identified which point out the difficulties that veterans have in obtaining the needed medical treatment. I would refer specifically to the case of a non-service connected veteran of World War II military service. The veteran is a complete quadriplegic and is currently on a breathing machine and has applied for admission to the Veterans Administration nursing home at the Tampa VA Hospital.

Although, at the present time, the nursing home has 56 available beds, they have not admitted the veteran and used the following as justification:

(1) They do not have sufficient staff to operate the additional 56 beds.

(2) The veteran is not receptive to rehabilitative medicine therefore, is not in their priority group for admission. The veteran has been placed in a public nursing home care unit on a six (6) month VA contract however, once this contract has expired, the veteran will be forced to use whatever sources he can locate in order to continue to receive the nursing care which his condition demands.

Another example of the same situation developing is at the Veterans Administration nursing care unit at the Miami Veterans Administration Hospital. Currently, the nursing care unit does not have a waiting list for admission to its nursing home. This, again, being due to the fact that the Screening Committee screens each applicant for admission to the nursing care unit to determine whether or not the individual has rehabilitation potential. If the individual solely needs custodial care, they are not admitted to their facility but, again, are generally referred out on a VA contract to a private nursing home, then, when the contract expires, it becomes the responsibility of the veteran and/or his family to find other sources available to provide for his care.

Mr. Chairman, the Veterans Administration recently completed a survey which was conducted by Louis Harris and Associates for the purposes of collecting data to assist the Veterans Administration in planning for the increasing aging veterans' population which will occur within the VA system during the next few years. The survey brought forth some very interesting statistics such as the fact that approximately 13% of those veterans interviewed indicated that they had cut back in medical care because of cost. The survey also pointed out that approximately ⅓ of those veterans who cannot afford proper medical care reported that they were in "poor health."

Mr. Chairman, the results of this survey clearly point out the fact that the budget reductions which are taking place in difference social programs and in the VA system itself are simply making "the poor poorer and the sick sicker." As the VA nursing home and domiciliary care units become more oriented toward providing admission only to those veterans who have "a rehabilitation potential," it becomes very apparent that those veterans who are in need of "long term non-acute medical care" are going to be forced to do without the necessary care or become reliant on the generosity of their family and friends to fund the needed medical services.

Mr. Chairman, what the survey pointed out to the VA is not new to Florida's veterans. They know first hand the effects an aging veterans' population has on the delivery of VA health care services.

Florida has the highest median age veteran population in the nation and is expected to maintain that position through the balance of this century.

Mr. Chairman, age has its effects on the body, older veterans are in need of more frequent and more intensive medical treatment than are younger veterans. Furthermore, their need for non-acute long term medical care is not something that we have to plan for in Florida, it is something that we have to address today. Tomorrow will be much too late for a great number of our senior veterans.

Mr. Chairman, this concludes my statement. I would like to express to you and to the members of this Subcommittee my sincere appreciation for your interest in and concern for the veterans who have sacrificed so much for this country.

STATEMENT OF RAYMOND G. O'NEILL, DIRECTOR, VETERANS SERVICE, STATE OF MICHIGAN, VFW

Messrs. Chairmen and Members of this Joint Committee Hearing: My name is Raymond G. O'Neill. I am the State Veterans Service Director, Department of Michigan, Veterans of Foreign Wars of the United States.

The purpose of my presence here today is to share with you the views of a Service Officer who works on the line—the eyeball contact with the veteran and his family, and I have been doing it for the past 33 years.

Although the thoughts I express will be based on my experience in the State of Michigan, they certainly will be reflective of the views of my fellow VFW Service Officers throughout this Nation.

We have a crisis on our hands. There are thousands of aged veterans out there who need special care and the Veterans Administration is unable to meet this demand. Additionally, there is a movement in the private medical sector to force the VA to accept medical care patients that are destined to become nursing care cases.

The VA recently released a report titled "Caring for the Older Veteran," an excellent presentation. In that part related to Extended Care Strategy, the VA has projected goals with completion dates by the year 1990 and 2000. This document should have been completed ten years ago with projected goals and completion date by the year 1985. If it had been accomplished, we would not find ourselves being overwhelmed by a rapidly aging veteran population.

It is necessary to point out that the VA within their present authority is doing everything within their power to meet this challenge. However, suddenly, without warning, an unforeseen development has occurred that threatens to crush the VA's acute medical care program.

I am talking about the private medical sector's practice of what is referred to as "dumping" brought on principally by DRGs (Diagnostic Related Groups). In this respect, Chairmen, I have attached to this testimony in the form of evidence, referrals to the VA Medical Centers Saginaw and Ann Arbor, together with an article related to this subject. In your review process, please note the outright deceit shown by some of the community hospitals in their advisement to the VA medical centers as to the condition of the patient. To illustrate—case #1 in the VA Medical Center Saginaw attachment shows the stated condition of patient prior to transfer—stroke victim (L) hemiplegia yet stable, able to talk and swallow, no catheter or IVs. Patient condition upon arrival to VAMC—patient found to have IVs infusing in (R) arm, slurred speech, left side weakness.

The cause of the dumping dilemma and, it does not take much imagination as to why, is the dollar bill. For example, you can readily appreciate that if a veteran was admitted to a private hospital under a particular diagnostic code that provided that the normal length of stay for that particular illness, say was 22 days, and had a cost factor of $10,500 and after the 12th day, the hospital discovers that it is going to take perhaps 45 days at a cost of $25,000, immediate efforts will be made to transfer the patient to the local VA hospital.

The Veterans of Foreign Wars feels that the Medicare regulations as it relates to the DRGs must be examined as to their impact on the VA and appropriate changes be made. This nightmare could eventually destroy the VA's ability to deliver acute medical care.

Earlier, I indicated that the VA's extended care capabilities cannot meet the demands of the eligible. In this regard, I do not want to leave a negative impression with the Committee of my feelings for the VA. It is quite to the contrary. I hold them in high esteem. For years I have worked on the line with their medical delivery people and I always found management and the medical personnel as being capable, concerned and compassionate.

In respect to my comments that the VA was ten years late in releasing a report titled "Caring for the Older Veteran" it is only fair and proper to state that during the period of 1975–78, the VA established eight Geriatric, Research, Education and Clinical Centers. The VA was in step with the times. The VA had the foresight and was out to do something about the aging problem of not only the veteran, but in the process, develop a plan to care for all aging Americans.

In 1980, the VA requested, and the Congress in their widom, authorized 15 centers, but no implementation—decremental budgeting took care of that, despite the fact that at the time, 27 percent of all American males over 65 years of age were veterans.

Finally, in my opening statement I set forth the contention that there were thousands of veterans out there needing nursing care and I am not one who believes in the myth that old age automatically brings illness; however, we do know that national figures show one of 20 individuals 65 or older lives in sheltered institutions.

In the Detroit metropolitan area, the VA medical center in Allen Park has a catchment area that covers 505,000 veterans and of this number, we have approximately 200,000 World War II veterans with an average age of 64 years of age and an additional 4,500 World War I veterans with an average age of 89 years of age.

This center, a 539 general medical and surgical hospital, has only 72 nursing care beds and a community nursing care budget that permits only 86 beds on a daily basis. The cited figure of one out of 20 indicates that within the next twelve months, the Allen Park catchment area will have over 10,000 veterans in need of nursing care.

We have a crisis on our hands. We can't wait until the year 1990.

This concludes my testimony, and I will be happy to respond to any questions you may have.

Veterans' Administration,
Medical Center,
Saginaw, MI, April 18, 1985.

Subj: Community Referrals to VA Admissions.

Mr. Ed Tucker,
Medical District Coordinator, Ann Arbor, MI

1. The purpose of this letter is to respond to your telephone request of April 14, 1985, identifying cases where services were denied or veterans were referred to our medical center by the private sector due to DRG's.

2. Due to the increased workload of respirator patients, management decided to take the following actions:

The medical center has targeted a quota of no more than five ventilator patients at any given time.

Physicians have been instructed not to accept patients requiring respirator care for transfer from community hospitals, if we reach five patients on ventilators. To date we have refused the transfer of two patients.

3. The attached list of incoming patient transfers cites cases where patient conditions were misrepresented in order to effect transfer to VA. We believe these are due to the growing concern for DRG's and their effect on community hospitals.

Gary L. Wilkinson, *Medical Center Director.*

Attachment.

Case 1: Patient transferred from: Tawas Hospital. Stated condition of patient prior to transfer: Stroke victim, (L) hemiplegia yet stable, able to talk and swallow, no catheter or IV's.

Patient's condition upon arrival to VAMC: Patient found to have IV's infusing in (R) arm, slurred speech, left side weakness. Admitted 12/17/84.

Case 2: Patient transferred form: Tawas Hospital. Stated condition of patient prior to transfer: Needs treatment for swollen left eye, friction burns and unkept physical problems.

Patient's condition upon arrival to VAMC: IV infused and catheters not previously reported by Tawas. Possible severe head trauma. Admitted 11/17/84.

Case 3: Patient transferred from: Flint Osteopathic Hospital. Stated condition of patient prior to transfer: COPD. Respiratory failure, on respirator, had decubital ulcers.

Patient's condition upon arrival to VAMC: Same as above, patient placed in ICU and then transferred to RCU and placed on the SI list in 8/24/84.

Case 4: Patient transferred from: St. Joseph Hospital. Stated condition of patient prior to transfer: Patient on respirator, general condition stable.

Patient's condition upon arrival to VAMC,: Same as above except patient considered unstable. Patient admitted 7/18/84 and placed on the SI list.

Case 5: Patient transferred from: St. Mary's Hospital. Stated condition of patient prior to transfer; Acute MI, trach with oxygen, and respirator. Patient considered stable.

Patient's condition upon arrival to VAMC: Same as above, except considered unstable. Patient admitted 11/1/84, placed on SI list.

Case 6: Patient transferred from: Cass City Hospital. Stated condition of patient prior to transfer: No prior contact from private hospital. Sent here by POV.

Patient's condition upon arrival to VAMC: Cirrhosis with ascites; R/O early ammonia toxicity. Immediately placed on SI

Case 7: Patient transferred from: Bad Axe Hospital emergency room. Stated condition of patient prior to transfer; Carcinoma of throat. Drinking alcohol.

Patient's condition upon arrival to VAMC: Same as above, except considered unstable. Patient admitted 3/25/85. Expired 3/26/85.

Case 8: Patient transferred from: Bay City Hospital. Stated condition of patient prior to transfer: C/A lung with metastases. C/O cough; weakness; some congestion. Accepted for examination. To be transported by POV.

Patient's condition upon arrival to VAMC: Same as above, but considered unstable. Bay Medical transported by ambulance without our knowledge. Admitted 3/9/85. Expired 3/10/85.

1. In the September 1 and 16, 1982, Hospitals magazine, there was a two-part special report entitled "The Dumping Dilemma: The Poor are Always with Some of Us." The article discusses what is known as "transfers of patients for economic reasons," "demarketing of services," etc. This is the practice referred to as "dumping" (a copy of the article is attached). Also attached are other articles related to this subject, and problems related to possible premature discharges.

2. At the Ann Arbor VA Medical Center there is some evidence that the medical center has been on the receiving end of this practice. Listed below are some examples of suspected dumping:

a. Patient transferred to the VA after 165 days of care at a private and a state university hospital due to failure to be weaned off of a ventilator. Patient was housed in the Medical ICU on a ventilator. The problem was the need for nursing home care for this type of patient, which was not available.

b. Patient transferred to the VA after seven days at a state university hospital, primary diagnosis of malfunctioning gastrostomy tube. This patient was transferred to the VA because insurance would not cover gastrostomy tube revision. He was admitted to the Surgical ICU for several months.

c. Patient spent 26 days in a private hospital with head injury following acute pulmonary arrest. His spouse indicated that he was transferred because "DRGs ran out."

d. Patient receiving radiation therapy for an inoperable brain tumor was transferred from a private hospital. They would not keep him as an inpatient because of DRG payment limitations (see attached newspaper article).

e. Because of limitations on Medicaid payments, 21 patients from a local nursing home were relocated. Three of these patients were veterans, which required intervention by the Ann Arbor VAMC in their relocation, including the incurrence of associated costs (see attached newspaper article).

3. Occupancy rates at the Ann Arbor VAMC have been extremely high during the past two fiscal years, due in part to acceptance of the above-cited cases. The patient waiting list averages five per day, with an average wait of up to one week for a bed. This has caused some problems with emergency patients. Recently, an ALS respiratory failure patient was sent to the state university hospital due to lack of ICU beds. After three days, this patient was returned to the VA, where he remained for over ten months in the ICU on a ventilator, and requiring a Clinitron bed. There are other cases also where patients have had to be sent to the university hospital at VA expense because of lack of ICU beds.

4. It is difficult to specifically identify all cases of suspected DRG-dumping because of individual circumstances. It is evident, however, that dumping is occurring and that the VA is the recipient in many instances. The type of cases involved usu-

ally are those of an unusual nature, called DRG "outliers" which are those where the length of hospital stay is beyond what a third party provider will reimburse for. The subsequent cost burden to care for these patients is being borne by the VA.

HOSPITAL SHUFFLE ANGERS WIDOW

(By Stephen Cain)

Seventy-year-old Ross Batzdorfer was bounced among three hospitals—a victim of the new medical economics and a major snafu—before he was allowed to die in peace of inoperable brain cancer at the Chelsea Medical Center last Oct. 22.

At one point, he was stuck for two hours in the back of a Huron Valley Ambulance Co. ambulance—acutely distressed, without medication and with his legs cramping—because St. Joseph Mercy Hospital near Ann Arbor wouldn't take him back and the Ann Arbor Veterans Administration Hospital initially wouldn't take him in.

It was—to put it most charitably—a breakdown in communication.

"Yes, I was mad . . . It's the worst example I've seen of a patient getting the fast shuffle because of the DRGs," complains family physician Jerry L. Waldyke, who was Batzdorfer's doctor at the beginning and at the end.

The DRGs (diagnostic related groups) are the new federal method of trying to reduce the hospital costs for treating elderly Medicare recipients. They put an economic premium on quickly discharging hospitalized patients or transferring them to other hospitals.

Waldyke said St. Joseph wanted Batzdorfer out because, under the DRG system, it probably wasn't going to be fully reimbursed for care provided after the cancer was diagnosed as inoperable.

Because of additional DRG regulations, the Chelsea Medical Center may not be paid $8,000-$10,000 for more than three weeks of hospital care it provided when it stepped in at the end to help Batzdorfer and his family.

Widow Ellen Batzdorfer says she is not interested in trying to sue anybody, but she does want the story told in the hope that this kind of thing won't happen again.

As pieced together from the medical records and interviews with Ellen Batzdorfer, four of the attending physicians and various hospital officials, here is the chronology of what happened.

Sept. 4: Ross Batzdorfer, a retired cost estimator with Federal Screw in Chelsea, fell out of bed in his Gregory home for the second time. He had been treated for the tremors and weaknesses of Parkinson's disease, a progressive nervous system disorder, since the late 1970s, but this was something more.

He was admitted to Chelsea Medical Center, a primary care community hospital where Waldyke and Ann Arbor neurologist Dr. Neill S. Hirst treated him for both the Parkinson's and what they came to suspect was a brain tumor.

An EKG and a CAT scan of the brain confirmed the tumor.

Sept. 16: Batzdorfer was transferred to St. Joseph Mercy Hospital into the care of Dr. S.M. Farhat, for further diagnosis and possible surgery. Everyone associated with the case agrees this was a routine and entirely appropriate transfer since Chelsea was not set up for the kind of surgery contemplated.

The tumor turned out to be inoperable.

"Dr. Farhat said Ross was not a candidate for surgery, which would completely paralyze his left side, and that even a biopsy could kill him" said Ellen Batzdorfer.

"They said they wanted him to have 20 treatments with nuclear radiation, five days in succession, off for the weekends, which St. Joseph does provide."

Sept. 19: Batzdorfer received the first of 15-minute nuclear radiation treatments at St. Joseph.

Then the trouble began.

"They started telling us we had to take him home," said Ellen Batzdorfer, "but I said I was all alone, that it was too far, and that I couldn't get him back and forth.

"Ross had no strength left in his left side. He was 160 pounds of dead weight, and I couldn't move him. All our neighbors are working or retired. My next door neighbor is 95 years old and couldn't help me.

"They wanted a nursing home, but the hospital social work department said they were all filled up and had long waiting lists."

Waldyke, one of the founding physicians at Chelsea as well as a member of the St. Joseph staff, said:

"With the time involved in making the diagnosis and starting treatment, Batzdorfer reached the end of where the government will pay. Were it not for the DRGs, I'm sure he would have been kept at St. Joseph's until the treatment was done or he was able to get out and care for himself."

Farhat disagreed, insisting that DRGs had nothing to do with his decision to seek alternate care for Batzdorfer:

"He did not need acute hospital care.

"I don't know what his DRG was, I have no idea on reimbursement, and I don't think moving him had anything to do with reimbursement, not from the physician's standpoint.

"It is inappropriate for someone who needs 15 minutes (per day) of radiation treatment to occupy an acute care bed. He occupied a bed needed by someone sicker than him."

Added Robert L. Ravin, the St. Joseph/Catherine McAuley Health Center associate administrator for medical services:

"To the best of my knowledge—and I really mean this—we have not discharged anybody saying, 'Hey now, you've used up your DRG.' "

Batzdorfer's daughter Linda Ori, a registered nurse visiting from Utah, mentioned to St. Joseph's social work department that "Dad's a veteran." Indeed, having received a Purple Heart for being shot by the Germans in World War II, having been a POW of the Germans and ultimately released with an honorable discharge, he was nearly the highest priority for VA treatment.

But the VA was reluctant, according to St. Joseph's officials.

"The social work department said the VA had said that his insurance was too good—Medicare with a Blue Cross rider—and that St. Joseph's should keep him," Ellen Batzdorfer said.

After several days of negotiation, St. Joseph's officials said VA had agreed to take Batzdorfer. The family was told that the Ann Arbor VA did not have nuclear radiation but could take him to University Hospital to receive the daily treatments.

"We were trying to see if he could get radiation at the VA or through the VA," siad Farhat. "We had a great length of conversation with Dr. (Martin) Bury in oncology at VA, and that led to the fact that Batzdorfer would be transferred and seen there.

"The social work department (at St. Joseph's) made the arrangements with Dr. Bury. We took a week for these arrangements, trying not to inconvenience the family. I'm surprised the efforts angered the family, didn't make them happy."

Bury, a fellow in oncology at both the U-M and VA, said he had talked twice to two of Farhat's residents but did not talk personally either with Farhat or anyone in St. Joseph's social work department.

He said he clearly explained to the residents that he would evaluate Batzdorfer as an *outpatient* in the oncology clinic and then make a decision on how his cae should be continued.

Sept. 26, St. Joseph's, acting on the assumption that it had arranged a hospital-to-hospital transfer, called Huron Valley Ambulance at 9:20 a.m. with an order to pick up Batzdorfer at 1:15 p.m. and deliver him for a 1:45 p.m. appointment in the VA's 7th floor oncology clinic, according to Huron Valley's records.

Ambulance crew members Joy Jorgenson and Jim Aksamit got Batzdorfer to the clinic at 1:54 p.m., only to discover it had closed for the day at noon, that Batzdorfer had been listed as an outpatient "no show" and that no one knew anything about arrangements for admission.

They reloaded Batzdorfer into the ambulance, called their dispatcher to try to sort things out and sent Ellen Batzdorfer—who had followed the ambulance in a car—back to St. Joseph's on the belief they would be returning there with her husband.

"Our dispatcher called St. Joseph's," said Dale Berry, Huron Valley's general manager. "The hospital didn't exactly refuse to take him back. They said they had discharged him.

STATEMENT OF CARLETON DALLERY, MSW, PH.D., DIRECTOR, DEPARTMENT OF SOCIAL SERVICES

As director of a hospital social work department, I oversee the placement of our patients in nursing homes. The term "placement" makes it sound like a simple process of expediting. However, the reality is that the process of placing patients from hospital into a nursing home is usually complex, time-consuming, emotionally draining, expensive to hospital and family, and more and more often just plain futile.

The burdens and agonies of nursing home placement from the acute care hospital do not result from conflicting goals or values. There is general agreement that no one should go to a nursing home who can be supported in a less restricted and more familiar environment. The troubles arise because of regulatory requirements that must be met before a person can be admitted to a nursing home with coverage by Medical Assistance or Veterans Administration. As you know, some areas of our country are experiencing severe shortages of beds for Medical Assistance patients, because reimbursement rates do not meet costs. In those communities, the acute care hospitals have to maintain many patients in acute care beds while they wait for lesser level of care beds outside the hospital. Waiting periods over one year are not uncommon. Sometimes patients who cannot get Medical Assistance nursing home beds will be taken home by families who have no experience in long-term care of the deteriorating and bedridden person, and who consequently find themselves sooner or later exhausted, socially isolated, unable to hope for the patient's improvement and unwilling to wish for his or her death—which all too frequently is the only way the situation can be relieved. We all like to say it is better to die at home, but there are fewer and fewer households that can be a home in which the dying process can be tolerated.

Let me focus now on the situation of the hospitalized veteran needing nursing home care after discharge. As I called social workers of other hospitals to get information for my statement today, I was impressed that every single one responded to my request with a kind of choking sound whose meaning was clear enough: getting aftercare for veterans is an awful process. One worker said it very poignantly, "in so many words, our job is to tell the veteran's family, 'you can't get there from here.'"

Since most medical episodes are unforeseen, families take patients to their preferred or nearest hospital, and that is usually not a Veterans Administration Hospital. From the acute care hospital, a veteran cannot be admitted directly to a VA nursing home. He or she must be admitted first to the VA acute care hospital. The VA hospital may refuse the patient on sound medical grounds or because of lack of beds. The paper work involved in having someone admitted to the VA hospital from a community hospital is extensive, and the approval process typically takes days or weeks. It is no wonder then, that hospital social workers are forced to—as one of them said—become "inventive." In other words, instead of the social worker effecting a smooth transfer of the patient from one hospital to the other, the family is obliged to take the patient home, provide for his or her needs there, and somehow get him or her admitted into the VA system on their own. Frequently, major risks have to be run, whole families must be mobilized, and strings must be pulled.

I find it entirely reasonable that a hospital social worker enters into a VA placement case with a feeling of dread. The worker must start the assessment and application as early as possible. Very frequently, the process begins at a point where the patient's eventual status is unpredictable, and the patient and family are still hoping against hope for a better outcome, like return to home and everyday life. Just when patient and family are having to come to grips with the acute episode, and are barely able to acknowledge that something is wrong, they must begin to assemble numerous documents concerning their life history, financial resources, military records, and sometimes legal history. The family who wants to hold on to hope will understandably be antagonistic to the social worker who asks them to begin talking about nursing home placement. The social worker has to accept the role of "bad guy." During this same early phase of planning, the social worker must bring the medical evaluation forms to the patient's physician. If the patient's course is still unpredictable, the physician will likely object that it is premature to take time out to fill out the forms; and the social worker must then struggle with the physician to achieve the result of having the forms completed and sped on their way to the VA system. As the process goes on, the increasingly common final phase is what we in hospitals call "the over-stay," when the patient remains in the acute hospital waiting for a VA bed to open up. During that phase, the hospital loses money, the physician becomes extremely vexed, and the family suffers the discomfort of knowing that they "should" take patient home to save the hospital money, but cannot provide the needed care. Often, the families fear, and sometimes justifiably, that less than adequate attention will be given to their loved one during the over-stay period. I personally know of several families who have exhausted themselves physically, emotionally, and financially exploring alternatives to VA placement, even though they have been given the infomation that no other option will work. Psychologically, this frantic searching is easy to undersand. It is a very, very sad thing to watch.

I have also had the personal experience of having to tell an elder veteran that while he may very well be entitled to care within the VA system, he is not eligible, or the service is not available at this timel This veteran at first insisted that I must be wrong. I might as well have told him that his mother did not love him any more and had sent official notification to the effect. When I told him he might have to apply for welfare and medical assistance, he asked me how I could offend the ears of a veteran with words like that. At that point it was my job to help this man accept the reality of additional physical disability and the offending reality of a system he could not understand but those rules must be followed.

Let me close with a general remark about the emerging medical assistance system for nursing home care. It is hardly a back-up to the gaps in Veterans Administration services. The processes of application, evaluation, and approval have become more time-consuming, have introduced new sources of arbitrariness, and have confronted patients with a formalized interviewing process that many of us have found to be lengthy and even insulting to the patient. How many of us could sustain a formal questioning process for two full hours while lying in a hospital bed enduring whatever discomfort and distresses our illness and medication have thrust on us? And yet, at least in Pennsylvania, the hospital patient must submit to a two-hour interview by a perfect stranger in order to be accepted into a nursing home under Medical Assistance. Again, in the name of diverting people from expensive nursing homes, when everyone would agree is worth doing, another layer of and another awful chore for patient and social worker.

In conclusion, I offer the observation that our patients and their families still believe that somehow their needs for medical care and nursing home care will be met. There is, after all, Medicare, Medical Assistance, and the Veterans Administration. Securing care within any of those systems is more and more frequently like a bad dream, and is often more distresing than the physical problems suffered by the patient.

I would like to be found wrong, but it seems to me that the net amount of misery associated with hospitalization has increased many fold and for many many people in the last four years.

STATEMENT OF JON HUNTER, DIRECTOR, AREA AGENCY ON AGING

ISSUES OF COLLABORATION BETWEEN COMMUNITY-BASED CARE SYSTEMS AND THE VETERANS ADMINISTRATION

I am Jon Hunter, director of the Area Agency on Aging in Fairmont, West Viginia. I am a veteran. I am also treasurer of the Board of Directors of the National Association of Area Agencies on Aging, which is a member of the executive committee of the leadership council of aging organizations. Today, I am speaking on behalf of the leadership council of aging organizations.

The 29 members of the leadership council represents consumers, providers and planners of community-based services that primarily exist to assist older persons in maintaining their well-being, independence and dignity as long as possible in the community. These services include senior employment, congregate and home-delivered meals, adult day-health, in-home nursing care as well as many others. Community-based services are funded by Federal resources such as the Older Americans Act and social services block grant, State and local government revenues, as well as private resources. Howerver, resources for community-based care are very limited.

The rapidly growing population age 60 and over necessitates a community-based long-term care system responsive to its varying needs. Now, one of every nine persons is over the age of 65; within 50 years one in every six persons will be in that category. In fifty years, the aging population will grow from 23 million to 55 million. In a speech at the second annual conference on long term care in 1982, Dr. Paul Haber, Veterans Administration Assistant Chief Medical Director for extended care, said:

The VA is faced with a rapidly expanding veterans population above the age of 60. This necessitates increased attention to developing alternatives to costly in-hospital programs for our beneficiaries requiring long-term care. More effective utilization and integration of existing extended-care programs is essential. There is a concomitant national awareness concerning the ability of Federal agencies to fully meet the long-term care needs of veterans and other elderly patients.

While the aging network faces the widely publicized "Graying of America", and the attendant exponential growth of the frail elderly population, the veterans network more particularly is gearing up to meet the World War II veterans bulge, which threatens to swamp the VA health care system. While the percentage of total population who are veterans is declining, the veteran population 65 years and over is expected to grow from four million to nine million by the latter 1990's.

There are no mandates nor suggested formal linkages between community-based aging services and the veterans services network but the common interest of the two networks in older persons has brought them together in some communities in many diverse ways. The networks have shared facilities, resources and information, as well as served each other's clients.

In pratically every State and in most local regions, one can find a Veteran of Foreign Wars or an American Legion hall serving as a senior center or nutrition site. In Murray, Iowa, a Veterans Administration Service Officer regularly assists VA applicants at a nutrition site. In Crossville, Tennessee, the local chapter of the American Legion uses a senior center as an American Legion hall.

In Denver, Colorado, the VA contracts with the senior transportation program to provide transportation for veterans and their families. Also, the area agency on aging has coordinated housing options for VA hospital patients returning to the community.

Veterans are also served by the Older Americans Act Title V Senior Employment Program. The VFW in Niles, Michigan has placed a bookkeeper and a custodian who had worked in title V slots on its permanent payroll. Equally important, wives of disabled veterans have been placed in title V slots working to supplement their husbands' VA pensions.

Information and referral centers routinely include in their inventories of resources, information on current veterans' benefits. They make frequent referrals to the broad operation of VA services. A case management project in St. Joseph, Michigan in which 16 percent of the clients are World War I veterans or wives of veterans, files for VA benefits on behalf of their clients with the assistance of the local VA service representative.

In Des Moines, Iowa, a social services officer from the VA hospital works closely with the case management program in planning for the orderly discharge of veterans returning to the community. Arrangements are made for appropriate Older Americans Act in-home services, including homemaker, home health aides, chore services and home-delivered meals assisting older veterans in maintaining their independence as long as possible.

The area agency on aging in Columbia, South Carolina has included the Veterans Administration in its Robert Wood Johnson Foundation Grant Program. Aimed at providing case management and service coordination for health-impaired elders, the project gives the VA direct access to the area agencies on agings' computerized client-tracking system.

In my own service area, we have a formal memorandum of agreement with the Louis A. Johnson VA Medical Center which outlines service coordination/case management for veterans and joint training of staff between the VA, the area agency and local community-based service providers.

In fact, one of the VA staff members serves on my regional advisory council representing veterans.

It would be impossible to present a complete list of the ways the two networks can work together, but these examples do provide some perspective in current cooperative efforts. These examples in certain communities have not grown from Federal mandates but rather were born of necessity and the recognition of our common concerns and missions.

It is important to note that these examples are not representative of the national picture but rather local unique initiatives. In actuality in certain parts of the country, there are fragmented relationships between the community care and VA systems. This may be due, in part, to the lack of a national policy on long-term care and more specifically due to no formal relationship between the Older American Act and VA programs.

The situation shows signs of only growing worse. With VA hospital and nursing home beds filled; with VA and community home care at capacity; with nursing home beds, in general, filled; the flood of new clients can only be disastrous.

What causes us considerable consternation is that neither the VA system nor the aging network currently has the capacity to handle the surge. The cornerstone for development and coordination of the community-based, in-home care system is title III–B, the most seriously neglected of all Older American Act titles. We need to underscore that community-based resources are being stretched exceedingly thin, and our capacity to meet the needs of the growing ranks of older veterans as well as the Nation's elders, in general, is diminishing.

With these current constraints most obvious, we are very concerned about the 1986 budget proposals which include a means test for VA services thereby limiting access of veterans to care, reducing new construction funds and converting some hospital beds to extended care beds.

The proposed means test is a significant policy change for the VA. Many older vets would be forced to use medicare as the first payer, when previously they had used VA benefits. Many health care costs now borne by the VA system for veterans 65 and over will therefore be shifted to Medicare. Obviously this cost shift will not save Federal resources, except the portion that would now be required to be paid as copayments by veterans themselves under the proposed Medicare changes.

The proposed VA budget contains funding for the proposed two new nursing homes, down from the eight previously planned for in fiscal year 1986. Reducing construction funds may be an easy option to implement with few apparent short-term repercussions. However, considering the elderly veteran population, it appears to be a short-sighted option.

The conversion of as many as 2,500 acute-care hospital beds to extended, or nursing home use, does respond to increasing long-term care needs by veterans and reduces the need to build more nursing homes. However, we would suggest the VA carefully study its future need for acute-care beds. We further suggest the VA conduct a cost-benefits analysis of utilizing alternative community based service when appropriate to reduce the need for both acute- and extended-care beds.

Although we can cite many examples of coordination between community care service systems and the Veterans Administration, there are policy and administrative barriers that exist, limiting further cooperation at a time when coordinated planning is critical to better serving older veterans. These hindrances include:

(1) Lack of a national policy regarding the relationship between institutional and community-care service systems,

(2) Administration budet proposals which will further imit access to needed services for older veterans, and

(3) Lack of enough flexibility within the Veterans Administration to develop mechanisms to pay for services outside its own system.

Therefore, I would like to suggest the following recommendations as an attempt to begin to overcome these administrative and policy barriers:

(1) The Veterans Administration must further encourage its institutions to develop formal agreements with the local community-based service systems to assure care coordination for individuals and their families. It is critical that working relationships exists between VA hospitals and community-care services such as home health, rehabilitative adult day health, home-delivered meals, etc. This may be accomplished through agreements with the area agency on aging, a community-wide case management program, or the individual provider agency. It is critical that both the VA staff and community service providers clearly understand how their services are accessed and administered. This provides assurance that older veterans do not slip between the two systems, or are under served, thus causing them to return to higher cost institutional care.

(2) The Veterans Administration must work with its field institutions to encourage the development of payment mechanisms allowing VA funds to be utilized for purchase of service contracts. Older veterans being discharged from a VA hospital may be in need of community-based services such as chore services, senior transportation, etc. which a VA institution may not provide itself. Many local providers report that a VA social worker may wish to refer their VA nursing home resident to community-based adult day health thereby assisting the veteran to return back to the community. However, the VA social worker finds it impossible to work through the VA bureaucracy to develop a way to release funds that could be used to purchase services "outside" the VA walls for the patient.

(3) The Veterans Administration needs to give special consideration for supporting or developing transportation services for veterans in rural areas needing to access VA or appropriate community services. This critical need could again be addressed through a purchase of service contract with a community senior transportation provider. Such an agreement may be much more cost efficient than developing a new service that the VA may not currently provide.

(4) The Veterans Administration should encourage co-location of senior services. For example, an under used VA facility could be utilized for community services serving both veteran and non-veteran seniors. A VA eligibility worker could use a community senior center as an information center for veterans living in the community.

(5) The Veterans Administration should encourage cooperative training of VA and community services staff. Such training should include basic information about each other's service systems. Professionals in both groups are constantly seeking information on such social and health issues as caring for Alzheimer's victims, family support care, etc. These training opportunities should also be available to local veteran

groups, who may be workers and volunteers within the systems as well as possible consumers in the future.

These recommendations represent activities that may exist in some communities across the country. However, many of them are impossible to implement without administrative and policy direction from the Veterans Administration here in Washington. Therefore, the leadership council of aging organizations encourages your serious consideration of these operational recommendations to improve the working relationship between the Veterans Administration care system and community-based care systems in order to serve the ever increasing number of older veterans in this country.

STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION, AGING VETERANS BY BARRY JACOBSEN

I am Barry Jacobsen, chief operating officer of the Willows Convalescent Centers in Minneapolis, Minnesota. I am pleased to be here to represent the American Health Care Association (AHCA). AHCA is the nation's largest association of long term care providers with a membership of over 8,500 facility-based providers in 49 states. This includes both proprietary and nonproprietary facilities providing a wide range of services in a variety of institutional settings. Our association is dedicated to quality long term health care for the nation's elderly, convalescent and chronically ill.

We appreciate the opportunity to present our views regarding problems and opportunities that result from the interaction of health policies for older veterans with those for the elderly at large. Indeed, the gradual aging of America's population will have a major impact on our society in the next 50 years. It is worth noting that the number of elderly—65 years or older—will more than double again by 2030, but even more significant, is the fact that a large component of that population group will be World War II and Korean Conflict veterans. Under current eligibility rules, this fact will mean that by that time, two out of every three elderly males in the United States will be eligible for Veterans Administration (VA) medical care if they elect to use it. Most veterans over 65 will (and already do) also have coverage under Medicare. But because recent Medicare policies have continued to propose increased out-of-pocket costs to the elderly individuals, in addition to more restriction of benefits, changes in use of medical services by veterans may result. Ultimately, the VA health care system may be the system of choice (or possibly the only system available to veterans) when health care is required.

As the representative organization of the long term care industry, we empathize with the VA as they face the challenge of providing health care to a growing veteran population. It is inevitable that in order to respond to this dilemma, the VA must re-evaluate the health care services they currently provide to their beneficiaries and to project what changes are needed in their program.

My principal purpose here today is twofold. First to discuss community programs currently being utilized by the VA in the provision of health care services to the elderly veterans, and second, to suggest other health service alternatives rendered in the community which the VA might consider using in meeting the long term health care needs of these individuals.

MEDICARE BENEFIT

Before addressing these issues, I want to comment briefly on a related concern being addressed at the hearing today—namely the impact of the Administration's proposed means test on the veteran and on the cost to the Medicare program. I view of the large number of beneficiaries currently dependent on the Medicare program as well as money being spent annually to operate it, the possibility of more beneficiaries in the program is cause for congressional concern. Generally, this patient care shift would apply to hospitals more than nursing homes.

The skilled nursing facility benefit is a very small component of the Medicare program: therefore, it is not likely to be affected by a transfer of veteran patients from the VA to Medicare. AHCA believes that Medicare's current cumbersome reimbursement and paperwork system and its coverage policies deter long term health care facilities from participating in the Medicare program. As a result, many Medicare beneficiaries in need of SNF are unable to receive appropriate care and are "backed-up" in expensive hospitals longer than necessary awaiting SNF placement. In our view, if veterans are shifted from the VA to the Medicare system, they may not be able to find available SNF beds and, although technically eligible, won't receive their Medicare benefit.

AHCA has long supported the development and implementation of a prospective reimbursement system for SNFs under Medicare as means for increasing provider participation. Until that takes place, the availability of SNF community nursing home beds will continue to be limited.

VA CONTRACT COMMUNITY NURSING HOME PROGRAMS

For the past 20 years, Veterans Administratioin Medical Centers have been contracting with local community nursing homes for the placement of veteran patients in their facilities. Medical centers negotiate all inclusive rates with nursing homes (room, meals, physician, nursing, pharmacy, lab and other services). Community nursing homes wishing to participate in the VA's program must meet state, federal and VA standards to assure that veteran patients placed in these facilities are receiving quality care. Usually, the medical center sends an interdisciplinary inspection team to make sure the community nursing home can meet the particular needs of a specific patient. The VA then refers appropriate patients (those whose needs the nursing home can meet) to the community nursing home. While the patient is a resident of that facility, the VA follows up with expert consultation and makes periodic visits as the conditions and progress of the patient. These visits usually include a social worker and often a nurse and special therapists who have worked with the veteran previously.

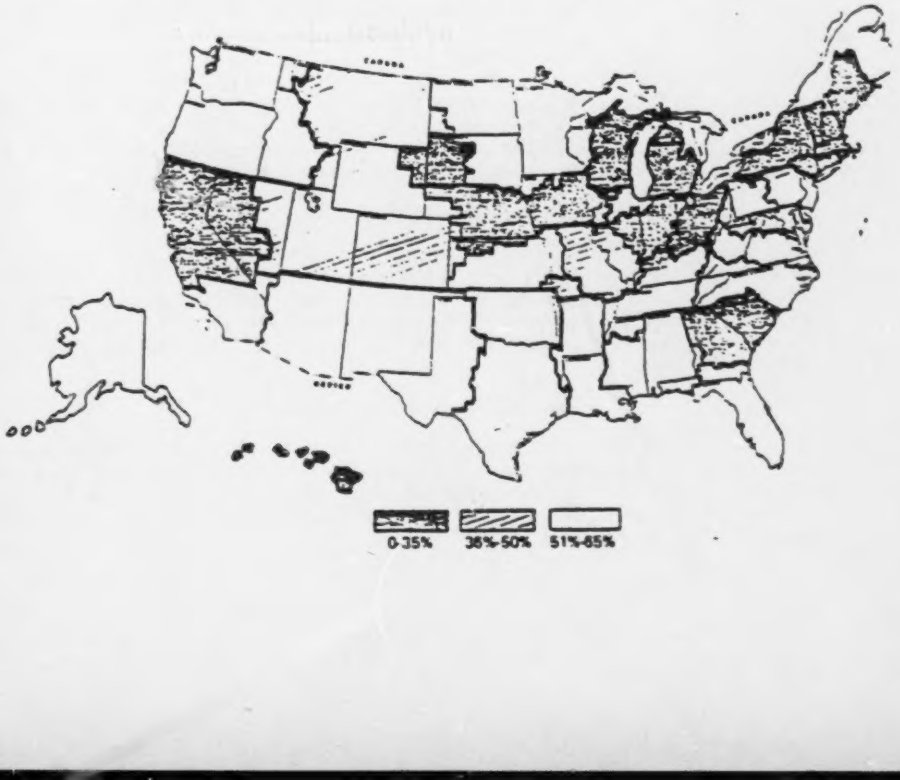
Successes

In our view, the community nursing home progress is a success. Community nursing homes enjoy their involvement with the Veterans Administration contract program. First, facilities' staff benefit from the expert consulatation and ongoing exchange with the medical center. Furthermore, the VA is known for paying their bills on time. Most importantly, AHCA has been told by the VA's Office of Extended Care that the VA has been satisfied with the quality care being provided in community nursing homes and its relationships with these homes.

Veterans placed in these facilities seem to be pleased with community nursing home placement. It is important to note that they are able to live closer to their friends and families than they might if residing in VA medical center hospitals and nursing homes. Community nursing homes provide a mixed male-female environment while most VA facilities are exclusively male.

In 1983, the community nursing home program supported an average daily census of 10,212 veterans, and supported the treatment of 34,092 total veteran patients. A small increase is expected in these numbers within the next few years.

Percent of Veterans Receiving Care in Community Nursing Homes



With respect to program costs, in 1983 the Veterans Administration reported that the average per diem cost for providing service in its own nursing homes was $93.01 while costs for contracting with community nursing homes averaged $50.68 per day. We recognize a portion of this difference may be due to larger staff levels and higher salary rates in VA nursing homes. Nevertheless, we are convinced that community nursing homes do provide quality care while meeting VA standards and at a lower cost than in VA facilities.

The General Accounting Office is currently studying whether the care needs of VA nursing home patients are higher than the needs of veterans in community nursing homes. This should provide information as to whether higher costs in VA nursing homes are justified and whether veterans have unique health care needs. That study is due later this year.

The success of the contract community nursing home is one example of how the VA can address the problem of caring for the aging veterans. The contract program can and should be expanded. In analyzing the VA's FY86 budget, we were disappointed to see that no request was made for expansion of this cost-effective, worthwhile program. However, we were pleased to see the introduction of Congressman Robert Edgar's (D-PA) bill, H.R. 505, which would facilitate better access to community nursing homes.

Expansion

AHCA believes that increased participation by the VA in the contract nursing home program may be expanded through negotiation of reimbursement rates with payment made according to special patient care requirements. In this way, patients requiring highly specialized heavy care would carry a higher reimbursement than those needing lesser care. In addition, there could be a special reimbursement system for provider services for veterans requiring an exceptionally high level of care when the costs exceed current statutory limits. For example, community nursing homes might develop special units to care for veterans with more acute needs such as the spinal cord injured or respirator dependent. Such an arrangement would necessitate a reimbursement rate which would reasonably compensate a facility for the costs associated with the special care required for these patients.

A member of our association from Michigan recently provided us with comparison costs of providing care to medically stable ventilator dependent patients in a community nursing home with the cost of similar patients in a community hospital. According to his information, this cost for patients in his nursing home's ventilator units are estimated to be approximately $300 per day. Hospital costs of such patients are averaging $906 per day. If VA hospital cost figures for ventilator patients are similar to community hospital costs, each patient placed in a nursing home ventilator unit could save the VA approximately $219,000 per year.

Regarding other recommendation for expansion of the contract community nursing home program, the possibility of altering the conditions agreed to in contracts between the VA and community homes might be considered. Extending the annual renewal requirement may be worth consideration to allow for more accurate long-range planning for both the VA medical centers and community nursing home administrators. In addition, VA medical centers may wish to consider contracting for a specified number of beds in a community facility to assure availability when it is required. In areas where VA nursing home beds are needed but the required number of beds are available in the community, this arrangement may be preferable to VA nursing home construction and certainly less costly.

ADULT DAY CARE

We are pleased that the VA has also been considering other available community resources which might provide services to the elderly veteran. Legislation passed in 1983 authorized the VA to contract with private adult day health care programs and to provide in kind VA services to the private or public program. AHCA members with adult day care programs look forward to working with the VA in the development of this program.

OTHER COST-SAVINGS PROPOSALS

Several weeks ago, AHCA testified before the House Veterans Affairs Committee Health and Hospital Subcommittee regarding VA health facility construction. In our testimony, we provided the subcommittee with recommendations regarding private construction of nursing homes which the VA could lease for its use or the leasing by the VA of existing private nursing homes.

Specifically:

1. Private construction of a nursing home which the VA could lease for its use. The facility would be privately built but operated by the VA to care for VA patients.

2. Private construction of a nursing home which the VA could lease for its use. However, in this case, the VA would contract out the management and staffing of the facility to care for VA patients. This would resemble the current contract program, but all patients, rather than just a few, would be placed in the facility by the VA.

3. Leasing by the VA of existing private nursing homes.

4. Contracting by the VA of a floor or a wing of a private facility in addition to the current program of contracting single beds.

Within AHCA's membership, there are several long term care companies which would be interested in constructing facilities and managing facilities for the VA's use. We believe this arrangement could be advantageous to the VA since demographic data indicates that the peak number of veterans in need of long term care will occur within the next twenty years. With long term leases, the VA could have the use of these facilities for twenty years. After its needs subside, the agency would not have empty beds with which to contend or "the empty school house syndrome," as it is called.

Since that hearing, further discussions of these proposals have been held by AHCA with House Veterans Committee staff. The results of those meetings disclosed a need for cost data which would compare building specifications of an existing VA nursing home facility with that of a community facility. We intend to pursue this information and will be happy to provide it to the two committees as soon as it is available.

VETERANS' GROUPS

AHCA believes that in recommending the proposals contained in today's testimony the involvement of the veterans, both the recipients themselves as well as the groups who represent them, should not be overlooked. In the past year, we have been in touch with representatives of all major veterans' groups and shared our thoughts and ideas with them. We welcome the opportunity to work with these organizations and their membership, especially on the state and local level. Some possible joint endeavors to involve them in community long term care might include volunteer and visitation programs and veteran employment initiatives.

SUMMARY

The American Health Care Association believes that to help meet anticipated needs for caring for the elderly veteran, the Veterans' Administration should increase its utilization of community nursing homes as well as consider other alternative arrangements for provision of needed services. The VA's mission to care for the nation's elderly veterans is not unlike that of AHCA's member facilities. We believe that working in concert with the VA to provide health care services more cost effectively while maintaining quality care for the patients, can be accomplished.

We would like the opportunity to develop programs which could explore new ideas to do this.

I would be happy to respond to your questions.

ATTACHMENT A

In a survey conducted earlier this year by AHCA, the following information regarding nursing home construction was received:

Only 8 of the 43 states listed[1] on the table below reported reasonable levels of construction activity. Tweleve states reported no construction at all, 4 reported additions to existing facilities only, and 19 reported low levels of construction. Of the latter, 14 states attributed the low level of construction activity to CON restrictions. Four states also indicated a significant level of hospital swing bed activity. These states were California and a cluster of states in Region VI: Montana, Wyoming, and North Dakota.

---

[1] Not reporting are Arizona, Arkansas, Louisiana, New Hampshire, New Mexico, Oklahoma and Pennsylvania.

CONSTRUCTION

NONE REPORTED

Alabama.[2]
Hawaii.
Idaho.
Minnesota.[2]
Mississippi.[2]
Missouri.[2]
Nevada.
New York.
North Carolina.
North Dakota.
South Carolina.
Texas.

HIGH LEVEL

California.
Colorado.
Florida.
Indiana.
Massachusetts.
New Jersey.
Rhode Island.
Tennessee.

ADDITIONS ONLY

Iowa.
Oregon.
South Dakota.
Utah.

HOSPITAL SWING BEDS

California.
Montana.
North Dakota.
Wyoming.

LOW LEVEL

Alaska.
Connecticut.[1]
Delaware.
Georgia.
Illinois.
Kansas.[1] [2]
Kentucky.[1]
Maine.[1]
Maryland.[1]
Michigan.[1]
Montana.[1]
Nebraska.[1]
Ohio.[1]
Vermont.[1]
Virginia.[1]
Washington.[1]
West Virgina.[1]
Wisconsin.[1]
Wyoming.

[1] Due to CON restrictions.
[2] CON moratorium on nursing home construction.

ATTACHMENT B

COST DATA FOR THE VARIOUS ALTERNATIVES PERTAINING TO LEASING BY THE VA OF PRIVATE NURSING HOME FACILITY

A PRIVATELY BUILT NURSING HOME LEASED AND OPERATED BY THE VA TO CARE FOR VA PATIENTS

The attached compares the estimated costs for a nursing home to be built in the Southwestern area of the United States by a major private corporation with the VA's cost estimation for its Tucson project. The VA estimates a $62,583.00 total cost per bed, while the private facility cost per bed would be nearly half, or $33,300.00. The VA estimates a cost per square foot is $173.81 while the private facility estimates $95.14. The estimated cost differentials are significant, yet, the private facility is a modern, well equipped, attractive facility which is not substandard by any description.

We were also informed by private nursing home developers that, on an average (and rates would vary depending on the geographic location), a facility built for the Veterans Administration subject to a triple net lease (i.e., VA paying maintenance, insurance and taxes) would lease for approximately $10 per square foot annually. For example, the VA could lease a 120 bed nursing home with 38,000 square feet for approximately $380,000 under a triple net lease option.

PRIVATELY CONSTRUCTED NURSING HOMES UNDER LEASE TO THE VA BUT WHERE THE VA WOULD ALSO CONTRACT OUT THE MANAGEMENT AND STAFFING OF THE FACILITY FOR CARE TO VA PATIENTS

This resembles the current contract program with the exception that the VA would now be doing the contracting under an entire facility basis.

The charge to the VA under this approach would include not only the square foot leasing charge described above, but also the operational costs associated with rendering patient care to VA patients. This rate would be negotiated between the facility and the VA and should take into consideration the level of patient need, geographic area and capital costs and any special staffing required by either the VA or the patient. We anticipate the figure arrived at would approximate the Medicaid rate plus 10-20%. (Note, most Medicaid rates do not include such items as physician visits, laboratory, pharmacy or other allied charges—the negotiated rate would include such items). Generally speaking, the per diem rate would probably be in the $60-$70 range.

LEASING BY THE VA OF EXISTING PRIVATE NURSING HOMES

The cost of leasing an existing private nursing home would be similar to the considerations described above.

CONTRACTING BY THE VA OF A FLOOR OR WING OF A PRIVATE FACILITY IN ADDITION TO THE CURRENT PROGRAM OF CONTRACTING SINGLE BEDS

Currently, the VA does contract with individual community nursing homes for long term care services. However, these arrangements are usually for only a few beds at a time, usually 5-10 beds per facility. In areas where the VA believes it needs additional beds but cannot justify the need for an entire new 60-120 bed nursing home unit, we suggest that the VA could possibly lease a floor or a wing of an existing community facility. Depending on the variables described earlier (geographic location, patient care needs, VA specifications and capital costs) we estimate the cost to the VA to be in the range of $60-70 per day per patient. If the patients remained in acute care VA units, the cost would be more than double this estimated amount.

Attachment.

COMPARATIVE CONSTRUCTION COST DATA OF COMMUNITY NURSING HOME WITH VA NURSING HOME

DESCRIPTION

Following is an example of a proposal for construction of a new 120-bed one-story skilled nursing facility based upon private corporation experience with current site, design, construction and equipment costs in the Southwestern area of the United States. The project includes 60 parking spaces.

Attached are conceptual floor and site plans.

The skilled nursing facility will be designed and constructed to meet requirements of all authorities having jurisdiction.

SCHEDULE

Private Project:
Program development, design—54 days.
Contract documents—60 days.
Jurisdictional plan review/permits—60 days.
Complete construction—11 months from start date.

Project cost summary	VA cost	Private project
New construction—43,209 gross square feet at $96.78	$4,182,000	
New construction—42,000 gross square feet at $74.29		$3,120,000
Land and site development		240,000
Sitework, parking, corridor	770,000	
Contingencies, reserves	644,000	
Technical services	420,000	156,000
Equipment	550,000	480,000
Inflation allowance	704,000	
Nonrecurring cost	160,000	
Utilities agreement	80,000	
Total	7,510,000	3,996,000
Total cost per bed	62,583.00	33,300.00
Total cost per square feet	173.81	95.14
Annual operating and staff costs:		
Total routine and labor per patient day	61.99	48.99
* Property cost	26.21	12.59
Total per patient day cost	87.21	61.58
Annual cost	3,628,830.00	2,562,344.00

---

[1] Property Cost calculation:
Private project based upon 80 percent financing at 12.75 percent, level debt service, 15-year term.
VA Tucson project based upon 100 percent financing at 11.625 percent (yield on Federal Hospital Insurance Trust Fund), 10-year term. (Interest was included in the VA project. Even though an interest factor may not be indicated in an appropriation, the cost to the government of borrowed money should still be taken into consideration.)

120 bed skilled nursing center—example of 40,000 SF facility.

60 bed nursing unit (2 required).

28 Semi-private rooms at 285 NSF; toilet w/lavatory and W.C., double closet/ wheelchair storage.

2 private rooms at 285 NSF; toilet w/lavatory, W.C., shower/wheelchair storage/ single closet.

2 Isolation room at 285 NSF; same as private room.

Lounge/Smoking Room; wall storage, glass to nurses station/TV.

Central bathing; 1 Bathing Room with toilet and lavatory at 180 SF; 4 Shower Rooms at 80 SF.

Nurses station:

Nurses counter and desk; movable chart rack/2 workstations.

Nourishment Station: Sink, counter, upright refrigerator (8–10 cu.ft.) Ice Machine.

Medications: 10' Counter, Sink, Counter Refrigerator and lockable cabinets, two medical carts/storage.

Staff Area—Charting Alcove (3 people) coat closet/Storage, Toilet, Purse Lockers (18), Window.

Patient care conference.

1 janitor's closet.

Clean linen storage (3 linen carts).

Clean utility: counter, sink, cabinets and adjustable shelves.

Soiled utility; flush sink, compartment sink, sanitizer, cabinets, undercounter cab.

Storage room.

Wheelchair storage.

Telephone/electric room/hot water heater; 3 soiled linen hold; circulation/corridors.

Support services (120 beds).

Administration:

Office Service Area.

Business Office (two people).

Social Services Office.

Conference Room (10 people).

Lobby/Lounge.

Reception Desk; share with Administration.

Public Toilets 2 at 80. Handicapped accessible.

Public telephones/water cooler.

Staff lounge (15 people) 2 toilets, kitchenette, vending machines, lockers, time clock.

Staff development alcove office.

Staff development area; wall storage/accessible to staff development office and administration, large enough for bed.

Director of nursing.

Physical therapy/occupational therapy:

3 treatment cubicles and therapy area

Hydro therapy.

Training toilet.

Storage.

Office/physical therapist at 100 SF.

Open therapy/exercise area.

Counter, deep well sink, storage, kiln room, closet, counter, cabinets, A.D.L. kitchen, adjustable shelves, display, director's office and access to outdoors.

Barber/beauty room—small entry seating area 2 stations/2 dryers.

Activities/storage/(access to outdoors).

Central supply and storage—space supply clerk/medical records.

Main dining room (60 people at 18.5 SF).

Skilled unit dining (30 people at 18.5 SF).

Patient lounge.

Kitchen:

Dietitian's office.

Walk-in freezer and cooler.

Dishwashing.

Dry storage.

Preparation.

Employee lockers (verify).

Toilet (1).

Janitor's closet.

Laundry: 2 washers/2 dryers/personal laundry—separated.

Clean linen storage (4 carts).

Soiled linen storage/processing 2 sinks.

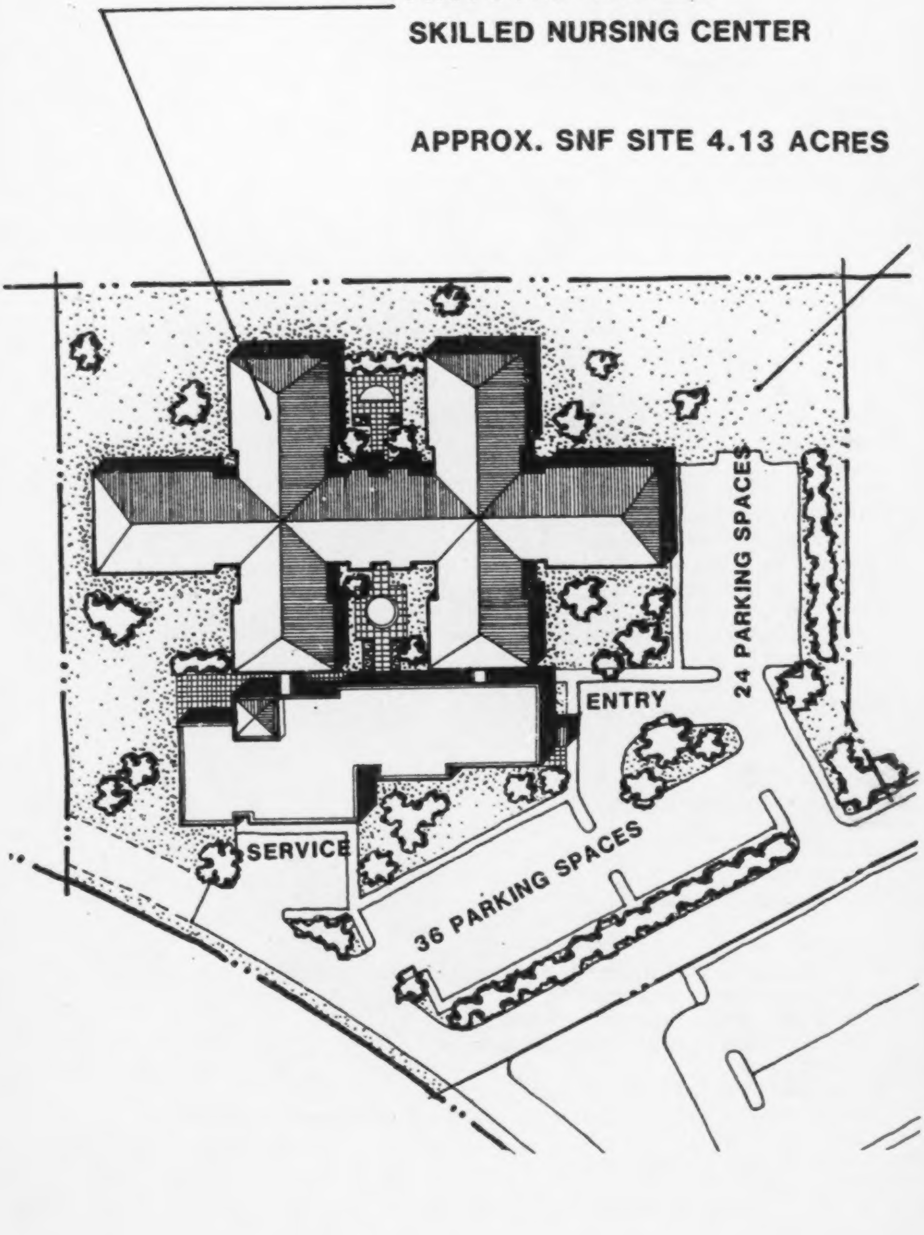
Building storage: maintenance alcove/workshop.

Oxygen storage.

Mechanical room: outdoor generator.

Janitor's closets: outdoor equipment storage (outbuilding at 150 SF).

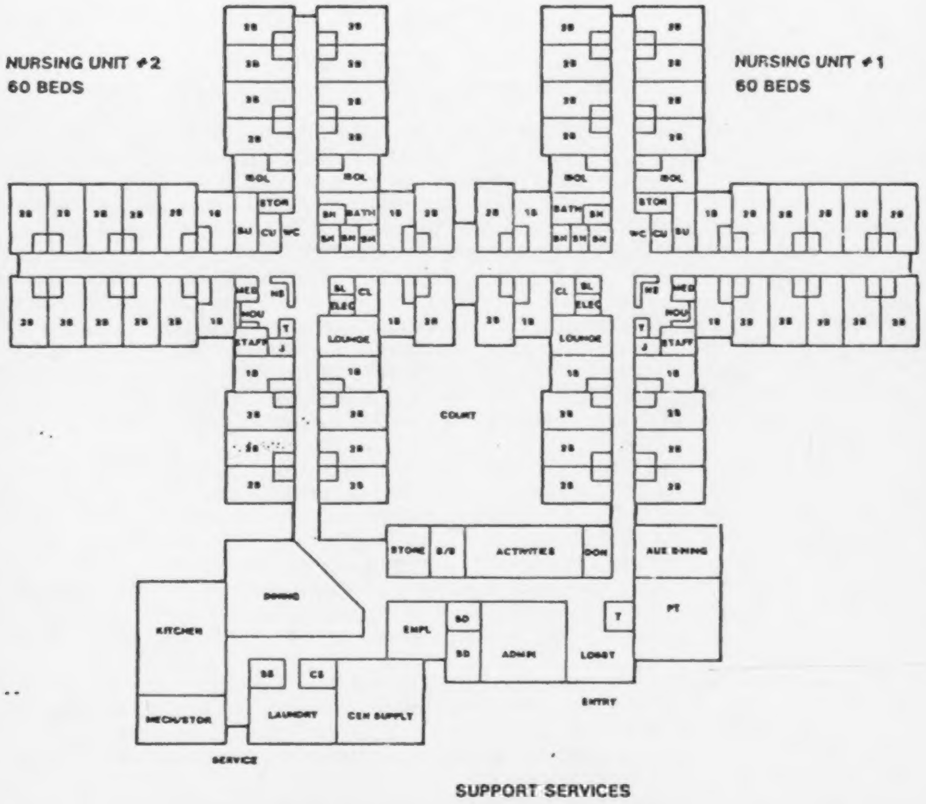
Circulation	1,800
Total area support services	12,200
Summary—120 beds Nursing (2 units at 14,150)	28,300
Support Services	12,200
Total Area—120 bed health center	40,500



PROPOSED 120 BED
SKILLED NURSING CENTER

APPROX. SNF SITE 4.13 ACRES

24 PARKING SPACES
ENTRY
SERVICE
36 PARKING SPACES



Testimony of John W. Rowe, M.D.

Mr. Chairman, I am Dr. John W. Rowe, a geriatrician interested in the health care of the elderly and in health policy. I serve as Director of the Division on Aging at Harvard Medical School, as Deputy Director of Harvard University's Division of Health Policy Research and Education, and as Director of the Veterans Administration's Geriatric Research Education Clinical Center or GRECC in Boston based at the West Roxbury Brockton V.A. Medical Center. I am pleased to have the opportunity to testify regarding the problems and opportunities related to the policies of the V.A. and other federal agencies in the care of the older veteran. This topic has been the focus of a major recent study conducted by me and my colleagues, particularly Dr. Terrie Wetle, at Harvard in cooperation with the V.A. and with the participation of several other federal agencies. This study has been summarized in the recently published volume "Older Veterans: Linking V.A. and Community Resources."

While the V.A. has developed an extensive and impressive array of services for older veterans, this has been accomplished in large part independently of similar developments in the non-V.A. sector and there has been relatively little integration and coordination of V.A. and non-V.A. geriatric resources.

This morning I will make two major points. First, that there is an urgent need for coordination, integration, and sharing of V.A. and non-V.A. geriatric health resources. As costs of health care increase and federal agencies attempt to limit their expenditures, older veterans are at risk of becoming the "boat people" of the health care system unless agencies coordinate their programs. Secondly, suggestions in recent reform proposals that the role of the V.A. as a provider of health care should be restricted or eliminated are particularly shortsighted and fail to take into account several unique strengths of the V.A. in the area of geriatric medicine.

Let me briefly outline the compelling rationale for increased sharing and coordination between V.A. and non-V.A. resources.

1. The number of older veterans is increasing very, very rapidly and will bring a markedly increased demand for health care.

2. Dual eligibility—all veterans over age 65 are currently eligible for V.A. health care, while 81 percent of these also qualify for Medicare and 4.2 percent qualify for Medicaid.

3. Our studies indicate the presence of a complex interaction between V.A. and non-V.A. components of health care—not purely a substitution of one for the other, but in many cases a complementarity. Changes in one portion of the health care system for the older veteran will have a dramatic effect on other portions of the system. Increasing costs in one sector will naturally drive patients with dual eligibility to the less restrictive or less expensive option. We project that if modes further increases in Medicare Part B cause only 10% of all elder veterans to leave local physicians as a source of care, the V.A. can anticipate an increase of roughly 15,000 veterans seeking hospitalization and 40,000 requesting outpatient care. Similarly, if the number of beds in community hospitals currently designated for long-term care is reduced by one-half in response to shifts in federal funding, the V.A. will see a significant increase in admissions, in the backlog of patients unable to be discharged from V.A. hospitals, and in the number of patents inappropriately placed in V.A. facilities.

4. There is substantial geographic variability in both the V.A. and non-V.A. components of care. For the V.A., while some areas have a substantial array of program most do not. There are 172 V.A. Medical Centers but only 43 hospital-based home care programs, only 10 GRECCs, and adult day health care programs are still limited to isolated demonstrations. Variability is also great in the non-V.A. sector with the availability of nursing home beds varying 5 fold among states and even greater variability being present in non-institutional resources. In view of these variabilities the potential complementarity and advantages of sharing of V.A. and non-V.A. resources is clear.

In view of the proposed budget cuts aimed at reducing the deficit and the strong tendency for federal agencies to resist coordination with other federal agencies in order to protect their own turf and budgets, I believe that Congressional action is needed to stimulate the V.A. and other federal agencies to coordinate and share resources for the benefit of older veterans.

My second major point relates to recent reform proposals suggesting that the V.A. medical care system be replaced wholly or partially with a system of publicly financed insurance for veterans. I believe that in the case of elderly veterans this proposal is particularly shortsighted. Let me provide just three reasons for my view, drawn from the recent analysis of my colleagues, Terrie Wetle and Mark Schlesinger.

First, it is widely recognized that the V.A. has taken a leadership role in the development of geriatric medicine in the United States. The well-developed and widely recognized GRECC programs; the excellent and extensive training programs in geriatric medicine, which currently are our major source of new geriatricians in this country; and the recent studies demonstrating the effectiveness of geriatric assessment units followed by the swift establishment of numerous such units in V.A. medical centers are examples of the V.A.'s innovative leadership in geriatrics.

Second, the V.A. has substantial advantages in the care of the elderly veteran since it is a centrally administered, vertically integrated system including multiple levels of care. Geriatric patients frequently move from long-term care settings to acute care setting and then back again to the long-term care institution. Within the V.A. these moves can be accomplished swiftly and inexpensively while in the non-V.A. components of the health care system such transfers are often delayed and require coordination of several agencies.

Third, as I mentioned earlier, regional variability is great with regard to the availability of geriatric care facilities in this country. While closing all V.A. long-term care facilities would be expected to add only 50,000 elder individuals a year to the non-V.A. long-term care system, in areas with a short supply of nursing home beds closure of V.A. facilities would induce chaos.

In view of these considerations, I believe we should move forward with a strategy for sharing of V.A. and non-V.A. resources, which takes into account special health needs of the elderly veteran and the relative strengths of the V.A. health care system in geriatric medicine. This concludes my remarks. I appreciate the opportunity to appear before this group and would be pleased to answer any questions. Thank you very much.

SUGGESTED PROJECTS

The following are suggested as projects which could be undertaken as a beginning effort. They are chosen as examples of specific options for VA/non-VA cooperative initiatives.

MODEL 1: IN-KIND EXCHANGE OF EXPERTISE AND SERVICES

The VA could offer the community a variety of services and expertise in exchange for access to community based long term care services for the aged veteran. In this model, both the VA and community engage in an exchange of services or expertise which the other party does not have available. It is our recommendation that the VA take an incremental approach to this type of sharing of in-kind resources by having the initial focus be at the VAMC, which is both convenient to large numbers of veterans and serves as the locus of demands for patient care.

COMPARISON OF LONG TERM CARE SERVICES OFFERED BY THE VA AND NON-VA SERVICE SYSTEMS

VA	Non-VA
Extended hospital care	Chronic disease and Rehabilitation.
Nursing home	Nursing Home.
Residential care	Foster care, board and care.
Domiciliary	Congregate housing.
Adult day health care	Day care.
Hospital based home care	Home health agencies.
	Home care programs.
	Social support.

What services should be exchanged will depend on service availability at the local level. The goal of this approach is to provide the veteran with access to a full array of services. The table above lists the extended care services offered by the VA and non-VA service systems. While there is considerable overlap in services, there are notable exceptions of in-home supportive services not provided by the VA. The table below provides a more detailed listing of services frequently available in the community that might be shared.

COMMUNITY LONG TERM CARE SERVICES AVAILABLE FOR SHARING

In the community	In the home
Lunch	Homemaker.
Day care	Chore.
Counseling	Companion.
Case management	Meals on wheels.
Legal	Personal emergency response.
Information and referral	Respite.
Protective services	Legal.
Transportation	Telephone reassurance.
	Information and referral.
	Protective services.

At the national level, there must be agreement in concept that sharing is worthwhile with standards set by Central Office of the Veterans Administration, the Administration on Aging, or other federal relevant agencies. Incentives provided to hospital administrators and agency directors for implementing guidelines at the field level could include:

Flexibility in guidelines.

Inclusion of community based activities in the performance appraisal process, and

Changes in the formula for allocating budgets to take into account in-home and outpatient long term care services.

In like manner, funding at the district level should take into account total program census, both acute and long term care.

To ensure that consistent incentives exist for both inpatient and outpatient care, it is essential that the VA develop a funding system for outpatient care which is adjusted for case mix. It is recognized that there are few existing models for an outpatient system of this type, but there is a growing data base as HMOs increasingly treat an older population. Medicare and other large third-party insurers are actively considering extending the concept of DRG-based hospital payments to ambulatory care. If the VA develops a system for case-mix adjusted outpatient funding, internal budgeting mechanisms are more likely to be compatible with reimbursement systems in the communty. This compatibility is likely to facilitate coordination and sharing of services between the VA and other providers.

These types of changes are already underway to a considerable extent. Changes in the existing system for allocating resources to VAMCs have been recently applied and incorporated into the DM & S budget process. The new method of allocating resources (Diagnosis Related Group acute care case mix system) defines a medical center's output based on the type and complexity of patient treatment and assigns corresponding cost based on resources consumed.

At the operational level, the VA has social work staff whose skills are appropriate for developing or expanding sharing arrangements with the community. Social workers provide discharge and after care planning, and community resource development and coordination. Each VA medical district has assigned a social worker to function as a community services coordinator to help to develop new programs and cooperative community arrangements. As the role of the Community Services Coordinators becomes established in the MEDIPP process with each VAMC, these staff can be expected to pay an important role as change agents in VA relations with community programs. Social work staff who function as information and referral coordinators would also be logical focal points for these efforts. Implementation of this option would use existing community services coordinators at the medical district and information and referral coordinators at VAMCs or add staff to this function where existing staffing levels are inadequate. It should be noted that this option is not intended to recommend exclusive use of one service to coordinate a community sharing effort. Rather, it suggests building on existing strengths of the MEDIPP process and the community coordination function of the VA social work service.

IMPLEMENTATION PLAN

In order to implement the option of exchange of in-kind services between the VA and the community, steps must be taken at all levels of management within the VA.

NATIONAL LEVEL

Central Office secures legislation necessary to redefine and expand sharing.

Central Office undertakes policy development to encourage sharing.

Central Office develops guidelines, standards, and incentives for implementation at districts and VAMCs.

Central Office secures and allocates resources to implement guidelines (see next section on costs).

Central Office monitors performance via annual performance appraisal process.

MEDICAL DISTRICT LEVEL

MEDIPP effort includes stage which requires interaction with community long term care system to identify areas of need that could be addressed by sharing.

The Medical District Plan which results from the MEDIPP process includes specific goals for VAMCs identifying areas where sharing long term care service with the community are needed as well as those agencies and organizations with which sharing arrangements might be developed.

Where necessary, the medical district distributes necessary resources to develop "sharing" arrangements to ensure support for the VAMC.

VAMC

VAMC director negotiates Memoranda of Understanding with appropriate agencies to engage in sharing.

VAMC director hires or reassigns staff as liaison(s) with community agencies.

Designated staff assist in developing cooperative community arrangements in priority areas.

Director executes formal interagency agreements for sharing.

Designated staff develop facility policies and procedures for sharing in accordance with policies of VA and community providers. (A special unit within the VAMC including the Chief of Social Work Service is recommended for this function.)

Designated staff develops procedures for monitoring of communication and exchange between the VA and the community by VAMC director.

Development of quality assurance mechanisms which include field travel to determine how well and to what extent needs of beneficiaries are being met.

BARRIERS

Barriers to implementation may require legislative and regulatory changes. Most importantly, the VA might need to redefine and expand "sharing" agreements permitted from those involving scarce medical resources to those which would allow broader VA community sharing. Specifically, the VA will need authorization to enter into contractual arrangements with the community to provide "in-kind" assistance through assignment of employees or "sharing" of other VA resources. A second barrier mentioned earlier is the current funding allocation formula which has focused in inpatient occupancy rates and which still emphasizes acute care case mix instead of the total program census. Other barriers to implementation include: attitudinal problems associated with a new way of doing business and the expansion of roles for some categories of staff; the complexity of coordinating activities; and concerns that sharing will not be equitable or direct.

MODEL 2: COORDINATION OF SERVICES AND PLANNING

Model 2 provides an example of coordination of services. In these types of collaboration both parties develop programs jointly in order to coordinate existing long term care planning and services. Coordination of planning and services can take place at the community, state, and federal levels. This particular model illustrates coordination between the state Medicaid agency and the Veterans Administration. There are advantages to coordinating services with state agencies. State governments are instrumental in setting policy for long term care, especially through the Medicaid program. Agreements between the VA and state Medicaid agencies, for example, could reduce costs for each while improving the quality of care received by elder veterans.

The VA currently places some 40% of its veterans requiring nursing home care in privately-owned facilities in the community. In so doing, the VA reduces the availability of beds for Medicaid enrollees. In many states in which the supply of beds is inadequate to meet the needs of all residents, this may increase the number of Medicaid enrollees who are forced to remain in hospitals while awaiting placement, leading to inappropriate and overly expensive care. It is thus in the interests of Medicaid to reduce the number of veterans placed in community nursing homes can be achieved through placements in other types of residential settings as well as by maintaining veterans in their own homes through community based services.

The VA has a number of options for residential care, including domiciliaries and community residential care. Placement of veterans in these types of facilities is to some extent hampered by the inability of the VA to currently supply an array of non-Medical extended care services. Medicaid and State Units on Aging, in contrast, are authorized to provide such services. It is therefore possible for the VA and state governments to establish arrangements under which the VA agrees to place an increased number of veterans who would otherwise be placed in community nursing homes in community residential care or domiciliaries in return for state supplied non-medical care to those veterans.

This type of arrangement promises to reduce costs to the Va, by shifting veterans to less expensive residential arrangements. It may also reduce costs to state governments by reducing inappropriate hospitalization and certainly will lead to a better match of needs and services for state Medicaid recipients.

IMPLEMENTATION STEPS—STATE LEVEL SERVICE COORDINATION

National Level

Central Office prepares recommendations for and secures any necessary changes in VA policy or legislation that would improve possibilities for coordination of VA services with state agencies involved in long term care.

Central Office engages in joint policy making with the Health Care Financing Administration and the Administration on Aging to encourage service delivery coordination between the Va, state Medicaid agencies and State Units on Aging.

Central Offices issued guidance to Medical Districts to have Community Services Coordinators enter into agreements, where possible, with state Medicaid and other relevant state agencies.

Medical District

The Medical District Director meets with state Medicaid Directors to discuss coordination of policy making, cooperation and mutual referrals.

The Director and/or Community Services Coordinator works out specifics of Memorandum of Understanding for areas of service coordination.

The Director executes MOUs.

Similar MOUs are negotiated with State Units on Aging and former Title XX Agencies (Social Service Block Grant Agencies).

VAMC

Existing VAMC staff use resources made available by executed formal agreements. Specific services will depend on the available community resources, services not provided by the VA in the area and the nature of formal agreements between the VA and the community. One or more of the following services would be most common; lunch, day care, counseling, case management, legal, information and referral, protective services, transportation, homemaker, chore, companion, meals on wheels, personal emergency response, respite, legal, telephone reassurance.)

LEGISLATION REQUIRED FOR SERVICE COORDINATION OPTION

The VA appears to have adequate legislative mandate to coordinate services with community and state agencies in the manner described above. Several changes in legislation wold, however, increase the flexibility of each VAMC to dovetail its services with those available in the local community. First, making uniform the eligibility requirements for nursing home, ambulatory, home health, domiciliary and residential care would ensure that services are provided based on the needs of veterans, rather than to meet the idiosyncracies of eligibility requirements. Second, it may be useful to have explicit legislative mandate of funding for coordination functions, ensuring that this activity is not "squeezed out" if the VA faces more restrictive budgets in the future.

SUMMARY

These two models are not intended to be exhaustive, but rather to provide examples of cooperative arrangements between Va and non-VA providers which would yield benefits to both service systems. The opportunities for such arrangements are many, and the specifics of implementation should be consistent with the special characteristics of each locale. What is important is the provision of a legislative, regulatory and administrative environment which provides encouragement and incentives to cooperative efforts and joint projects. Clear statements of intent from Congress and federal agencies will address many ofthe concerns of VA medical center directors and staff as well as providers in the aging network. The provision of relatively modest resources to help support start up costs of such efforts would also facilitate the program. The opportunity for cost savings through reductions in duplication and inefficient fragmentation is substantial. Most importantly, the provision of more appropriate and necessary services to elder veterans and non-veterans is the most desired outcome.

We hope that these clarifications are useful to you.

TESTIMONY OF DONALD L. CUSTIS, M.D.

I thank you for the privilege of testifying at this hearing before the Select Committee on Aging and the Subcommittee on Hospitals and Health Care. The joint nature of this heairng is in itself a recognition of the interrelationship of long term medical issues involving both the veteran and the nonveteran as well as the commonality of interest between the VA and the private sector health care systems.

The size and demands of the nation's aging phenomenon are not easily grasped, but the implications as extensively detailed in the medical and socioeconomic literature are certainly arresting. Ramifications of what has been called the "longevity revolution" are so broad and complex that it may well become the most compelling imperative driving the socioeconomic, political and ethical aspects of tomorrow's health care industry.

The data is irrefutable. Denial of its validity would be amusing, were the consequences not so serious. To ignore the problem will certainly not make it disappear. The choice available to the VA and to the Nation is not whether to deal with the problem, but how to deal with it.

That will require planning. Ironically, today's almost exclusive preoccupation with health care cost containment has fostered a mind set that a competitive medical market obviates the need for planning and that the coming impact of an aged citizenry is but a further aggravation in medical economics requiring a rationing of medical care.

Congressman Waxman has rightly stated that, "if we rely solely on competition in the health care market place, millions will be denied access to needed care, for no one competes for the poor, the unemployed or the chronically disabled". The highest incidence of that deprival is likely to be visisted on the swollen ranks of the elderly.

Although this is not the place for an extensive recital of demographic data, a quick reference to gross figures is perhaps in order.

Today, 30 million Americans are over the age of 65 with 2.6 million 85 or older. By the year 2000, there are expected to be 35 million over age 65 and 12 million of those in the over 75 category. To maintain current levels of care, the elderly will, by the year 2000, require a 68% increase in nursing home beds and a 25% increase in hospital beds. In more dramatic terms, it calls for the opening of a 200 bed nursing home every day for the next fifteen years.

The Veterans Administration faces even more immediate problems. Percentage aging of the 29 million veterans will occur at three times the rate projected for the society at large and will fully impact a decade before its peak in the general population. Eleven percent or 3 million veterans are currently over age 65, and by the year 2000 will reach 37%. In that year, two thirds of all American males over the age of 65 will be military veterans.

Mindful of this prospect, the VA Department of Medicine and Surgery began its study of the aging veteran impact eight years ago and published its initial analysis in 1977. Subsequently, a decentralized strategic planning process called MEDIPP was designed and implemented throughout the VA health care system. A supplementary effort resulted in the publication last year of a planning document entitled "Caring for the Older Veteran". The result of more than two years of study, advisory input, contract consultation and review, the plan provided an overview, based upon demographic projected need, of the opportunities presented by the aging of its constituents. Because the VA is dealing with a population whose average age is increasing much faster than that of the population in general, it was hoped that a VA accommodation to this impact would serve as a proving ground for national programs to follow. Through its research and demonstration activities in the geriatric area, the VA has already been a major contributor to the development of the existing body of knowledge in this field. The VA has the advantage of starting with an on-line comprehensive coordinated system which includes both the medical and social components considered essential to an effective geriatric effort. All the key elements of a basic structure to meet the spectrum of needs of the older veteran are either in place or they exist in pilot form. Their costs and potential use can be predicted with some confidence.

Unfortunately, this document failed to receive sanction as a strategic plan by OMB and all requests for incremental geriatric program implementation were denied in the fiscal year 1986 proposed budget. "Caring for the Older Veterans" remains, however, a valid demographic needs assessment. It was never intended that the VA health care system alone could achieve sufficient growth and resource capability for independent and complete satisfaction of this need. For this reason, other options were proposed for a greater dependency on contract care and sharing of facilities with the private sector. Most notable was a proposal to permit the VA to engage in joint cooperative efforts with local communities to develop and share non-institutionalization programs for the aged veteran and non-veteran. It was further suggested that Congress consider the provision of seed money to encourage the creation of such cooperative community geriatric structures in a manner not unlike that provided for AHECS—the Area Health Education Centers.

Your committees are to be commended on your effort to consider in some depth the underlying policy issues inherent in this aging phenomenon and hopefully to influence the focal point of Congress in further health care legislation. It would seem thus far that the federal government, in its effort to reduce health care costs, has invested almost exclusive faith in the efficiency of market principles and is placing full responsibility on the providers of care to render treatment within the financial limit set by virtue of fixed capitated payment or eventually go broke. Continued pursuit of this technique can only force additional and inequitable cost shifts, risk the compromise of the quality of medical care and assure the denial of care to many of those for whom there is no financial compensation.

The American Hospital Association, the Federal Hospital Association, the American Medical Association and many third party payers are now on record as opposing further arbitrary cuts in federal health care programs without proper regard for the consequences. Similarly, continued horizontal leveling of the VA health care system through arbitrary budget decrements will render it impotent to handle its share of the impact of the aging veteran. The time has come for Congress to better define what that VA share *is* to be and *how* it can best be handled. Those decisions should be made in the context of a comprehensive review and strategic reform process applied to all of the interrelated federal health care programs addressing the needs of the elderly and the disabled.

The case for such a review is well made in an excellent article appearing in Health Affairs by Dorothy Rice, the previous director of the National Center for Health Statistics and Carroll Estes, consultant to the U.S. Senate Committee on Aging. They contend that because of the changing composition of the elderly population the time has come when Congress should consider not simply spending reductions, but the very structure of Medicare itself.

The authors argue that such exploration is necessary because the medical care needs of the elderly are changing along with the complexion of this age group. Medicare is essentially a health insurance plan for acute illness. Very few of its resources finance chronic care and no coverage is provided for out-of-institution services. Medicaid provisions should be modified for more appropriate and equitable resource allocations. Programs are needed that would encourage a proportionate consumer sharing of financial costs for long-term care. The "all or nothing" rule of eligibility, requiring "spend down" to poverty level for welfare aid needs serious rethinking. This same pernicious principle is now a component element in OMB's proposed "means test" for veteran health care entitlement.

Finally, the authors have defined certain parameters of long-term care applicable to a systematic reconsideration of all such programs as Medicare, Medicaid, Social Security and the various government sponsored social services. And to which I would certainly include the VA medical and socioeconomic programs. Their guidance consists of four basic principles for measuring the effectiveness of long-term care policies: "First, it must be comprehensive, including a full range of health and social services covering the long-term care continuum from community-based care to institutional care. It must also include preventive and restorative services as well as treatment and illness management. Long-term care services must be linked with other health and social services as with hospital and physician services. Second, it must provide incentives for providers to keep costs at a reasonable level, to prevent overutilization and to promote the use of appropriate services. Third, it must have a financial system that provides protection from impoverishment to individuals who need long-term care, and that allows for combining private and public resources to assure protection for individuals before they become ill. Fourth, it must ensure access to those who need the services regardless of financial ability to pay and regardless of age or type of disability."

The proposal of Rice and Estes is ambitious, but the aging revolution and its coming impact on the nation's health systems justifies truly extraordinary measures to insure the availability of required resources. To repeat, the veteran population aging cycle is running a decade ahead of that for the population in general. This provides a unique opportunity to design and test optional models to serve needs of the elderly in the VA's controlled environment.

Because of the interest of the private sector in the success of such research and because of the VA's interest that society in fact develop programs which are then available to veterans, I would hope that your combined committees would consider the establishment of a National Congressional Commission on program review and health policy revision for the aged. Such a Commission should have a broad base of representation from all appropriate vested interests. Its purpose would include the analysis of different health care models, review of existing systems and the development of recommendations for Congressional guidance in the possible redesign of federal programs and the establishment of coherent health care policy for the elderly and disabled.

America's health care delivery systems are in great turmoil. Multiple vested interests and agents are studying health system restructuring and revenue reform. Long term care policies are under review in the Brookings Institute, the National Institute of Medicine, the AMA and the AAA. Unless the advocates of the elderly and disabled address the policy issues critical to their needs, their future will be shaped by the advocacy of others. The time for a Congressional review is propitious, particularly for the VA.

In determining the VA's role in the decade of the nineties, many questions need be posed, such as:

Should the VA health care system be "slowly shrunk" as advocated by OMB?

What share of long-term care of veterans should be provided within the system?

Does it provide a proving ground for long-term care models?

What is the potential and time table for shared non-institutionalized programs with community structures?

What modifications of VA care entitlement are in order?

Can an equitable, flexible and fair means test be devised?

Should there be a proportionate sharing of medical care costs by selected VA patients?

Is the expansion of third party reimbursement to the VA conceptionally sound?

What vertical reconstruction of VA facilities are needed?

Where should mission changes be applied?

What is essential in the system as regards health manpower production, research and contingency support of military medicine?

What is unique?

What are the guidelines for future VA hospital and nursing home construction?

If there is any foregone conclusion about the impact of the older veteran it is surely this; the cost of veterans' health care will significantly increase. The coming demand for care for all elderly citizens must somehow be met. What we all seek is not really cost reduction, but cost economy—with proper allowance for compassionate care. A concerted effort is needed to avoid the transformation of what has been and should be a humanitarian service into a business endeavor where the laws of economics may well become the all controlling influence for health care policy. Should that happen, the longevity revolution will become a forced reminder of humanitarian neglect and a national shame.

STATEMENT OF JOHN W. DITZLER, M.D., CHIEF MEDICAL DIRECTOR, DEPARTMENT OF MEDICINE AND SURGERY VETERANS ADMINISTRATION

Messrs. Chairman and Members of the Committee and Subcommittee: I am pleased to have the opportunity to discuss the challenge of providing health care to the aging veteran and opportunities that result from the interaction of policies for older veterans with policies of other Federal agencies.

Fifty years from now one of five American will be 65 years old or older. The doubling of this portion of the population has been popularly labelled "the graying of America." Understanding the impact of an aging population, and the basic changes in the social fabric which will likely result, is only now developing. For society at large, it seems like a problem of the future and tends to be put off while the urgent problems of the present are solved.

For one large group in the American population—America's veterans—the aging phenomenon or "geriatric imperative," and the changing needs which accompany it, is not a matter for future speculation. The Veterans Administration is dealing with a beneficiary population whose average age is increasing much faster than that of the population in general. In 1980, the proportion of veterans 65 and over was approximately the same as that in the general population. By 1990, it will be double the general population rate, and by 2000, nearly triple that rate.

It must be presumed that the Department of Medicine and Surgery of the VA has the responsibility to examine closely the alternatives likely to be available to meet the health care needs of eligible veterans. The VA also has the additional role of addressing other human services and income maintenance needs of elderly veterans.

All agencies of government that deal with the elderly have to meet the challenge of distributing resources most effectively. Moreover, this challenge carries with it a responsibility for VA—to develop and demonstrate effective approaches to the care of older veterans which can be observed and adapted by society at large as the general population ages.

The VA has been aware for some time of a very special opportunity and challenge it has as a result of the aging of its client population. Over the past decade, VA researchers and clinicians have been at the forefront of the developing field of gerontology and geriatrics—the study of aging and the care of aging members of a population, respectively. VA's gerontology research and training programs are a primary national resource preparing physicians and other health workers to deal with the problems of the aging. Special projects and individual VA medical center initiatives have developed and tested a variety of innovative, medically sound programs for meeting the needs of older persons. These programs have provided care in both institutional and community settings, often in cooperation with non-VA caregivers, educators and researchers.

For a number of years the term "geriatric imperative" had current and common usage in the VA. VA issued a report entitled "The Aging Veteran" in October of 1977, and the VA has worked for the past decade to develop programs in geriatric research, education, and clinical care including pilot programs to deal with the aging population. VA has conducted and supported studies and surveys to assemble information to try to get a real fix on what the challenge of the future was going to be. Last year the VA published a report entitled "Caring for the Older Veteran."

In developing this report a fundamental issue for us was to project the real need for future care for which the VA might be responsible. Since we had no reliable information on future changes in Medicare and Medicaid, we made our projection based on the assumption that Medicare and Medicaid would continue to meet the same needs as previously met. This meant that taking all veterans 55 and over in the country, same 37% of them had medicare coverage and for those 65 and over, about 90% of those veterans were covered by Medicare—both Parts A and B in most cases. Discussions and joint planning have been initiated with the Health Care Financing Administration and other governmental agencies involved in health care, to consider developing mutual projections for the future.

The need is difficult to quantify precisely. We worked on the report for over a year and developed three "real need" methodologies for projecting need out to the year 2020. These were compared with two demographic only projections, one by the Congressional Budget Office and one from our own MEDIPP data. The report does not contain specific program plans with detailed budget estimates but does contain strategic options for consideration. The report was not intended to be a plan, nor an appropriation or budget request. In fact, the assessment of future resource requirements is a dynamic variable of changing technology, health characteristic, economic conditions, availability of private sector health care, changes in VA eligibility, and other economic factors. Hence, budget imperatives cannot really be clearly enumerated until the 1987 budget.

Now I will shift the focus to those opportunities that VA has taken and is exploring where there is interaction of health programs for older veterans with other Federal and State agencies.

The Department of Medicine and Surgery is able to provide a comprehensive array of health care services to eligible veterans, ranging from acute medical care to adult day health care. However, the Department is not authorized to provide a broad spectrum of health related or social welfare services. For example, the Department does not provide, directly or through contract, home chore services, meal preparation, or shopping services.

Other avenues do make it possible for veterans to obtain these health related/social support services. First, certain veterans who receive service-connected compensation or the nonservice-connected pension benefits from the VA are eligible for additional income support based on conditions rendering them "permanently housebound" or in need of aid and attendance. These higher rates reflect an individual's disabilities, which require additional assistance in daily activities, and assist the individual veteran in purchasing needed and desired services. The second source of assistance for the older veteran in need of supportive services is the veteran's own community. The array of community-based programs, funded through Federal, state, local, and private agencies, is available to the frail elderly veteran as a citizen, although comprehensive community services are not universal.

While the VA operates within the context of its statutory authority, the Agency has concern for and is studying the role and future development of community-based health care and health related services. This remains a critical area of exploration, especially as these community services affect the quality of life of the elderly and the efficient and effective utilization of institutional health care. The Agency's report, "Caring for the Aging Veteran," and Harvard University's report "Older Veterans: Linking VA and Community Resources" contain numerous ideas and recommendations on future approaches to community based care and its systematic development and coordination. These concepts are receiving continued and intense review within the Agency.

At the medical centers, the VA interacts with community organizations on several levels: academic, administrative, professional/technical, and service delivery. The service delivery component, of particular interest here, is primarily intended to refer veterans to community health and social services following VA hospitalization. Service delivery components of VA/Community relationships are primarily, though not exclusively, part of the discharge planning process to assure that veterans receive health care and social services to support their post-hospital adjustment and to delay or eliminate the need for reinstitutionalization. This ongoing patient based referral function was reinforced and formalized in 1975 when the VA became a signatory Agency in the Working Agreement for the Consortium on Information and Referral Services to Older People, as part of the Older Americans Act Comprehensive Amendments of 1973. This Agreement was updated and revised in April 1983.

Nationally, the Department of Medicine and Surgery is working with the Administration on Aging (AoA) to develop an agreement for jointly sponsored demonstration projects for VA/AoA collaboration. These projects would focus on (1) providing specific (in some cases newly developed) services to caregivers and patients with Alzheimer's disease; (2) developing new, community based treatment alternatives; (3) developing effective models of collaborative case management to produce optimal use of community resources; and (4) developing collaborative education programs for the clinical staffs of the VA system and the aging network.

The VA is participating in a number of projects which should improve information systems on the elderly population and the utilization of long term care services. These initiatives are designed to avoid any duplication of effort.

First, as an outcome of the joint American Health Planning Association/VA Conference in September 1984, participants meeting in state groups set in motion the development of joint data systems among all members of the planning/service delivery community. Follow-up questionnaires of the participants show continued movement in that direction.

Second, the VA is one of five Federal agencies which is sponsoring a National Academy of Sciences project on Statistics for an Aging Population. The project will produce two major products over the next two years: a set of eight commissioned papers on various aspects of health, aging, and statistics, and a final report containing the panel's recommendations for statistical analyses of major policy issues in the field of aging and health.

At the local level, VA medical centers continue to participate in the development of, and actively use, community based resource directories for referral purposes, often funded by Area Agencies on Aging or the United Way. Additional efforts by all interested parties in this area will be necessary to better understand the user population, their needs, and the appropriate utilization of services.

One program where the VA can, to a limited extent, support resource development is adult day health care, under a provision of P.L. 98-160 which allows "in kind" assistance within a contractural setting. The VA remains committed to the exchange of information about benefits and services and to working with community agencies as contemplated in P.L. 98-528, "Coordination of Veterans Administration Health Care Services with State and Local Programs" and the Information and Referral Program referenced earlier. In summary, although VA alone cannot address all the issues in this area, we will continue to contribute its leadership and its expertise toward the care of the elderly. Finally, I would observe that the value of the VA is and must remain that of a health care system with acute medical capabilities ranging from preventative care through ambulatory care, acute inpatient primary through tertiary care and extended in-hospital and non-hospital care; the aging veteran needs all these services—not just an old folks home.

Messers. Chairmen, in preparing for this hearing you also asked a series of questions concerning our proposal to revise VA medical care eligibility.

We recently submitted to the Congress a draft bill that would revise eligibility for VA medical care. Let me set that proposal in context.

Historically, the primary mission of the VA health care system has been to furnish care to service-connected disabled veterans and to veterans unable to pay for needed medical care. In 1970, however, Congress extended eligibility for VA hospital and nursing home care to veterans 65 years of age and older, without regard to financial need. In sharp contrast, legal eligibility of most nonservice-connected veterans under 65 is based on their inability to defray the cost of needed VA care.

The law's disparate treatment of nonservice-connected veterans on the basis of age raises a serious issue. VA may only provide medical care to nonservice-connected veterans to the extent facilities and resources are available. Demographic projections indicate that the number of veterans who will be eligible for care as our veteran population ages is increasing significantly. Fairness dictates that age alone should not be a basis entitling one to VA care. Rather, VA should be treating those nonservice-connected veterans who lack the means to otbain such treatment elsewhere, regardless of age.

Our draft bill, accordingly, is intended to overcome this inequity. Our proposal would amend title 38 to authorize VA to determine that nonservice-connected veterans over the age of 65 who are not otherwise eligible for, and seek, VA care have a financial as well as a medical need to receive that care. This change would enable VA to sustain the quality of care provided to the most deserving veterans—those with service-connected disabilities and those without resources to defray all or part of their health care expenses.

The change would also clarify and extend a framework which Congress provided for in 1980 when it enacted Public Law 96-330 and deleted provisions of law prohibiting VA from looking behind a veteran's assertion of financial need.

Thus, the bill would specifically provide for the Administrator to promulgate regulations identifying the conditions under which veterans may be considered unable to defray medical expenses. It would also establish in law that a non-service-connected veteran whose total income and assets, as defined in the improved pension program, is below an eligibility level set at twice the VA pension rate—a level currently of just udner $15,000 for a veteran with one dependent—would be deemed unable to defray the cost of any needed health care.

Under this proposal, VA would continue to fulfill its primary mission of care for service-connected veterans. Furthermore, this proposal would not alter the role VA has played in providing medical care, within the limits of VA facilities, to other groups of veterans:

(1) Veterans who were prisoners of war;

(2) Veterans of the Spanish-American War, Indian Wars, Mexican border period or of World War I;

(3) Vietnam War veterans exposed to certain herbicides during military service;

(4) Certain veterans exposed to ionizing radiation during military service; and

(5) VA pensioners.

Enactment of this bill would enable VA to develop fair, effective screening system to help assure that those veterans with greatest need—the service-connected and the financially disadvantaed—can avail themselves of VA care. Regulations, provided for in the bill, would establish the circumstances under which a veteran, whose income and asset value exceed the proposed twice-pension-rate standard, would receive VA care. The central elements of this system, as applied to veterans with means above that standard, would provide for the following;

(1) In most cases, these veterans would not be eligible for VA health care unless the veteran's out-of-pocket medical expenses exceeded certain amounts.

(2) These out-of-pocket expenses, called the "expected medical expense contribution," would be an increasing share of the amount by which the total of the veteran's family income and asset value exceeds the eligibility level. This share would increase progressively with income, requiring higher income veterans to finance a larger amount of their medical expenses before entering the VA system.

(3) In emergency or extraordinary circumstances, these veterans could receive care in the VA system but would be billed for their share of the cost up to their expected medical expense contribution.

(4) In exceptional and unusual circumstances, the Administrator could waive in whole or in part the veteran's expected medical expense contribution in order to avoid substantial hardship.

Messrs. Chairmen, you asked that in preparing for this hearing we develop an analysis of the impact of our legislative proposal. As regards your questions about Medicaid impact, if a nonservice-connected veteran can establish entitlement to Medicaid assistance, that individual is deemed, for purposes of VA eligibility, unable to defray such expenses and would be admitted to receive VA medical services. Therefore, we foresee no impact on Medicaid. However, as to your concern for the part that Medicare benefits play in eligibility determinations, VA care is not intended to be a substitute for Medicare for veterans with Medicare coverage and incomes above double the maximum annual VA pension rate. We anticipate that these veterans would first seek care available to them through their Medicare coverage. However, after these veterans make out-of-pocket expenditures up to their expected medical expense contribution, they will be eligible for VA care. Veterans with Medicare eligibility and incomes below double the pension level will be admitted to VA facilities whether or not they have first used their Medicare benefits.

We do not foresee that the implementation of oru proposal to revise medical eligibility would in any way impair the quality of VA medical care, research, and education. However, enactment of such proposals and implementation of a screening mechanism would enable us to assure that VA health care resources are targeted to those most in need. We are confident that enactment of this proposal would assure fairness and permit the VA health care system to be more responsive to those veterans with the greatest need for, and highest claim to, its services.

U.S. Senate,
Committee on the Budget,
Washington, DC, April 5, 1985.

To: Republican Senators and Legislative Directors.
From: Steve Bell, Staff Director.
Re: Senate-White House Deficit Reduction Agreement.

Attached is a brief summary of the major provisions of the deficit-reduction agreement reached Thursday evening between the Senate Republican Leadership and the President.

Please Note: All numbers are subject to change during the next week. Aggregates (deficit numbers, outlays, revenues, etc.) however, will probably change very little.

SUMMARY

1. Real growth in defense will be 3 percent for Fiscal Years 1986, 1987, and 1988 (up from the Senate Budget Committee's reported resolution real growth rates of zero percent in Fiscal Year 1986, and 3 percent in both Fiscal Years 1987 and 1988);
2. Social Security recipients would get an automatic 2 percent Cost-of-Living-Adjustment (COLA) in all three Fiscal Years, instead of the one-year freeze recommended by the Senate Budget Committee;
3. Domestic spending cuts are slightly larger than in the Budget Committee recommendation;
4. No new taxes are recommended.

SUMMARY OF MAJOR PROPOSALS IN SENATE-WHITE HOUSE AGREEMENT—FUNCTION 700: VETERANS BENEFITS AND SERVICES

[Outlays in billions of dollars and fiscal years]

	Change from baseline			
	1985	1986	1987	1988
2 percent compensation and pension COLA		−0.2	−0.5	−0.8
Increase VA housing loan origination fee		−0.4	−0.4	−0.3
Reform VA hospital and medical care		−0.4	−0.7	−0.8
Total change from baseline		−1.0	−1.6	−2.0

Allow 2 percent cost-of-living adjustment for compensation and pension programs. The Senate-White House agreement proposes a 2 percent COLA for the veterans income security programs in fiscal year 1986, fiscal year 1987, and fiscal year 1988. This adjustment is consistent with the recommended increase for social security and other federal pensions plans.

Increase VA housing loan origination fee. The agreement recommends increasing the VA housing loan origination fee from 1 to 3.8 percent. The proposed fee corresponds to the current premium for FHA mortgage insurance. The fee collections will be deposited into the VA Loan Guaranty Revolving Fund and will contribute to the fund's solvency.

Reform VA hospital and medical care. The agreement proposes two major reforms to VA hospitals and medical care:

Reform of VA health care eligibility through the implementation of a means test for non-service-connected veterans regardless of age; and

Allow the VA to recover the cost of non-service-connected care provided to privately insured veterans.

These reforms will contribute to deficit reduction by curbing the VA's history of inflationary spending for medical services. Finally, these reforms will allow the VA to direct scarce resources to caring for the service-connected-disabled veteran.

STATEMENT FOR THE RECORD BY CAROL FRASER FISK, ACTING COMMISSIONER ON AGING

I welcome the opportunity today to present to the Select Committee on Aging and the Subcommittee on Hospitals and Health Care of the Committee on Veterans Affairs a brief account of the activities relating to older veterans in which the Administration on Aging is engaged.

The Administration on Aging is currently working with the State and area agencies on aging to insure that they will be able to respond properly to the needs of all older persons, including older veterans.

To address these needs, State and area agencies will have to increase their current capacities in several ways. First, due to the fact that the older population is increasing in absolute numbers, the Administration on Aging anticipates a need to expand the capacity to increase services. This will entail making more effective use of existing resources, creating partnerships and linkages among public, voluntary and for-profit organizations and adopting more cost-effective approaches to service delivery. Second, because the needs of the older population are changing at the same time that the elderly are increasing in numbers, we will have to be sensitive to the need for a variety of new services, especially innovative forms of home and family care. In this connection, we will need to identify ways in which we can assist families with older veterans to better help themselves and avoid unnecessary institutionalization. Older veterans as well as other segments of the older population will be able to benefit from an improved array of home and family oriented services. The Administration on Aging has been working closely with the Veterans Administration to develop the capacity of both networks to meet future needs.

The Administration on Aging is also working with other Federal agencies on matters of concern to older veterans. For example, the Administration on Aging and the Veterans Administration have joined with the National Institute on Aging, the National Aeronautics and Space Administration, and the National Institute of Handicapped Research to apply aerospace technology to the product needs of older persons.

In addition, the Administration on Aging is encouraging State and area agencies on aging to work with counterparts of the Veterans Administration at the community level. A number of the Long-term Care Gerontology Centers supported by the Administration on Aging are already working with components of the Veterans Administration to improve services to older persons. For example, with Wisconsin Long-term Care Gerontology Center has assisted the Wood Veterans Administration Hospital in exploring the potential for a working relationship between the Veterans Administration and the Wisconsin "Community Options Program" (a system for delivering services to targeted populations) in Milwaukee County. In Portland, Oregon the Pacific Northwest Long-term Care Gerontology Center, the Oregon State Unit on Aging, the local Area Agency on Aging and the Veterans Administration are exploring the possibility of collaborative planning for a service-integration project targeted to older veterans at risk of institutionalization. The Suncoast Long-term Care Gerontology Center completed a research project in which a survey instrument for determining the "functional status" of older persons was developed and then applied in determining functional status differences among elderly Veterans Administration patients in four distinct long-term care settings. The Suncoast Center is also providing technical assistance in the establishment of a Geriatric Dentistry Program to benefit older veterans.

In Dallas, the Veterans Administration and the Southwest Long-term Care Gerontology Center are developing an application for an adult day care center. The Temple University Long-term Care Gerontology Center is convening a planning group consisting of the Pennsylvania Department of Aging, the Department of Public Welfare, and the Regional Office of the Veterans Administration to improve the coordination of aging and welfare services with the services provided by the Veterans Administration. The University of the City of Los Angeles/University of Southern California Long-term Care Gerontology Center is working with the Veterans Administration in various ways, such as assisting in the development of a geriatric assessment instrument to determine the health status of older veterans and designing several training programs for Veterans Administration staff.

STATEMENT FOR THE RECORD OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Chairman Roybal and Chairman Edgar: I am pleased to have this opportunity to present an analysis of the potential impact on Medicare and Medicaid of a proposal under development by the Administration to reform the eligibility requirements for Veterans Administration (VA) medical services. This report has been prepared at the request of the House Select Committee on Aging and the House Veterans Affairs Subcommittee on Hospitals and Health.

PROPOSAL

At present, the VA provides free health care to veterans on a space-available basis. Priority is given to veterans with service-connected disabilities. The proposal would add a means test for use of VA medical services by veterans age 65 and over without a service-connected disability. (These individuals are termed "non-service-connected" veterans). A means test already exists in principle for non-service-connected veterans under age 65, but it is not fully effective; this proposal would also make this provision more effective. Veterans with service-connected disabilities and certain other categories of veterans, such as World War I veterans or those exposed to Agent Orange, would not be subjected to the means test.

The proposal would affect only those non-service-connected veterans with incomes over twice the veterans pension amount. Individuals with incomes over this ceiling would be expected to contribute a specified fraction of their income over the ceiling on out-of-pocket medical expenses (the "expected medical expense contribution") before they would be eligible for VA medical services.

ASSUMPTIONS

Final, official estimates of the numbers of veterans affected by the reform, and of their characteristics, were not available at the time this analysis was conducted. The Health Care Financing Administration (HCFA) has no way to make such estimates independently, since neither our administrative nor our research data bases contain information on the veterans status of Medicare and Medicaid beneficiaries, or on their utilization of VA medical services. Consequently, in our analysis we have been forced to make a number of simplifying assumptions that may or may not be supported be actual experience if this reform were enacted.

The effect on costs also depends on what medical services will be used by the new recipients. Unfortunately, we have no way of knowing what the utilization patterns of the former VA-eligible cases will be once they are in a differrent medical reimbursement environment. In the absence of better information, we have assumed that the veterans affected by the eligibility reform will have the same medical utilization patterns as other Medicare beneficiaries.

It should be pointed out that veterans presently utilizing VA health care services may also be receiving Medicare benefits in the same year. Therefore, our analysis does not deal with persons moving from one system to another. Rather, it deals primarily with admissions that are moved from the VA system to the Medicare system.

The effect of the proposed reform on the Medicare and Medicaid programs depends critically on the size of the flow of veterans between these programs and VA programs. Estimating the size of this flow would require information on the number of veterans made ineligible for VA medical services, on the proportion of these that would be eligible for Medicare, and on the fraction that would actually use Medicare-reimbursed services.

Because of the data limitations noted earlier, HCFA is not in the position to estimate the size of this flow. For the sake of this analysis, therefore, we have adopted the expedient of presenting results for three different assumed levels of Medicare caseload increases and are assuming no reverse flow, i.e. lower income veterans presently receiving Medicare benefits would not transfer to the VA. Committee members and staff may choose which of these levels seems most appropriate. We make no specific recommendations. The estimates shown are proportional to the size of the flow, and they can easily be adjusted to account for smaller or larger flows.

We have assumed that the usage of Medicare after 1986 would grow in proportion to the growth in the number of veterans over age 65. Projections of the expected growth of this group were provided by the Veterans Administration.

IMPACT ON HCFA PROGRAMS

Medicare outlays

I am submitting a table which shows the net impact of the proposal on total Medicare outlays net of part B premiums. The table shows three scenarios, defined by the assumed level of increased hospital admissions that would result from the proposal. The first panel of the table shows the cost for both part A and part B services for 10,000, 20,000 and 30,000 additional admissions in Fiscal Year 1986, with growth in subsequent years corresponding to the growth of the veteran population. The first panel costs include part B costs per admission that are unassociated with hospitalization.

In addition, the reform will result in additional part B services being used by individuals who are not hospitalized during the year. Accordingly, the second panel shows the increase in part B outlays for part B-only users. In general, we would expect each additional Medicare-reimbursed hospital admission to be accompanied by an increase of approximately 1.3 individuals who use part B services during the year, but who are not hospitalized. Thus, the three levels of part-B only use displayed are those we would normally expect to correspond to the level of hospital admissions for the three scenarios. For example, under Medicare's normal experience, 10,000 additional admissions can be expected to be associated with an additional 12,900 people using part B services over the course of a year.

The final panel of the table shows the total of these two parts for the three different, hypothetical scenarios.

MEDICARE SOLVENCY THROUGH 1995

If the actual effects on Medicare outlays approximate those shown in the table, the effect of the proposal on Medicare solvency through 1995 is essentially insignificant. Annual Medicare outlays in FY 1986 are estimated at approximately $74 billion; the amounts shown in the table are about two-tenths of one percent of this amount.

MEDICAID

We have assumed for purposes of these preliminary estimates that there would be no effect on Medicaid. Since the individuals no longer eligible for VA programs would be relatively affluent, it is not likely they could qualify for Medicaid. This would be true even if they have catastrophic medical expenses, since the expected medical expense contribution provision of the proposal. which is less stringent than "spend-down" provisions of Medicaid, would permit those in this situation to qualify for VA medical services long before they could qualify for Medicaid.

In closing, I must emphasize that these estimates are preliminary. It has been necessary at a number of points to rely on very crude assumptions about the size and composition of the effects. Consequently, these estimates should be used with caution.

I hope this report will be of assistance to you in your legislative deliberations.

ESTIMATED IMPACT OF VA MEDICAL SERVICES ELIGIBILITY REFORM ON MEDICARE COSTS UNDER THREE HYPOTHETICAL SCENARIOS

[Dollars in millions and fiscal years]

Scenario	Increase in hospital admissions (1986)	Outlays net of part B premiums				
		1986	1987	1988	1989	1990
PANEL I. HOSPITAL ADMISSIONS: PART A AND PART B COSTS INCLUDING PART B COSTS UNASSOCIATED WITH HOSPITALIZATION						
A	10,000	$50	$59	$70	$81	$93
B	20,000	100	118	140	161	186
C	30,000	150	178	209	242	279
PANEL II. PART B ONLY USE						
A	[1] 12,900	3	3	4	5	7
B	[1] 25,800	6	7	8	11	13
C	[1] 38,700	8	10	13	16	20
PANEL III. TOTAL						
A		53	63	74	86	100
B		106	125	148	172	199
C		158	188	222	258	299

[1] Increase in part B only users (1986).

N.B.: Detail may not add to totals because of rounding.

Statement of Veterans of World War I of the U.S.A., Inc., by John Pavlik

Mr. Chairman and Members of this Distinguished Committee: we are pleased to have the privilege of presenting to you, the thinking and feelings of the Veterans of World War I, the "old soldiers of 1917-1918." with regards to older veterans health care issues.

Most projections prepared dealing with the older veterans make projections to the year 2000. With our current average age of 89 years old today, in the year 2000 the veterans of World War I will be 104+. Time is of the essense for your Buddies.

As the National Commander of the Veterans of World War I, I present our wish for the Veterans Administration to develop, or support, non-institutional long-term care service, based on V.A. facilities, home and community programs.

We would like to see the programs for the establishment of Geriatric Evaluation Units in the system's hospitals and the increase of V.A. provided or supported, inpatient bed capacity.

More specifically, we would like to see the reinstatement of V.A. medical programs wherein due to transportation problems for our aging veterans, the veterans are treated in their own hometown, by their own long-time physicians who have taken a personal and professional interest in not only the veteran but also the welfare of the veteran's family, and the reimbursement for medications obtained at their own local drugstores.

When our veterans developed seeing problems, the VA fitted the veteran with glasses. When his hearing failed, he was fitted for a hearing aid. Now, that the World War I veteran's teeth are in need of special attention, consideration should be given for the fitting of "dentures". We are only referring to "dentures" and not routine dental care which is currently reserved for a small group of veterans. Our aging needs are NOW!

The Public Laws enacted by the Congress for needy Veterans, (P.L. 2, P.L. 86-211, P.L. 95-588, and P.L. 96-151), simply do not reach many thousands of World War I veterans due to the restrictions contained in the Laws or due to the mental and physical immobility of the veteran. Certainly you can not sacrifice the care of war veterans to balance the budget.

We realize that there has been a reluctance to separate veterans according to wars. But, the veterans of World War I are of another age, apart from all previous wars. Mostly volunteers, or citizen soldiers, when the war was won, we grabbed our service discharges and $60.00 clothing allowance and proudly called it a deal. There were no V.A. Hospitals, just an informal medical inspection which would show no loss of arms or legs, and we were civilians. Little did we realize that many had been exposed to mustard gas which would years later, cause lesions in the lungs ending in T.B.

Time and again this Subcommittee has proven itself to be a friend of the veteran. But in view of the desire of the Administration to hold down federal spending, the stiff competition that exists for available federal dollars and the difficulties that all standing Committees are experiencing with budget committee recommendations, we realize that you are working in an atmosphere that makes for difficult decisions. That is to say, total resources made available through the appropriations and budgetary process cannot encompass all of the objectives that this Subcommittee may wish to pursue. Yet, notwithstanding the realities to present economic conditions, we do believe that no federal beneficiary has a greater or more moral claim for constant and fair health care for the aging veteran of World War I, for a generation which had experienced the horrors of the Western Front; horrors of such magnitude that "Gone West" was a synonym for death for 20 years after World War I.

We are the elderly veterans of today. The majority of our hospital cases are terminal cases and should be considered such. We want now the same kind of services and care that is being planned for the veterans of World War II; not to be lessened in quality or quantity.

Our Buddies need the out-patient care, prescriptions through the V.A. regardless of service-connected disability, and anything else to ease the pains of growing old, with dignity.

Sixty-eight years ago, this Nation had a critical special need and nearly 4.5 million young Americans placed their services and their lives on the line to answer that need. Today, the aged remnants of that proud young Army have a special need from the Great Nation they defended.

Mr. Chairman, by allowing us this time we know that you remember our veterans and their unique needs. For this you have the profound gratitude of our organization. We are most appreciative of the special effort this Subcommittee has always made in meeting the need of America's wartime veterans.

We sincerely hope that Congress will consider the health and medical problems of World War I veterans in a compassionate light.

Thank you for the opportunity to speak before this Committee.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

Chairman Roybal to Mr. Aviles, Disabled American Veterans

Question. 1. How do you think the individual veteran will react when he is told that he cannot count on the VA in his older years, and, in fact, must "spend down" his family income before becoming eligible for VA care?

Answer. The concept of "spending down" as the means of establishing eligibility for Veterans Administration health care has a number of ramifications which, from my point of view, have not been adequately addressed as to the impact that they will have on the veteran population which is rapidly approaching the time when they will become more dependent upon the VA Health Care system as their primary provider of health care services.

In general, most veterans feel that the concept of "spending down" is totally unfair to them as individuals. Most veterans are not financially in a situation which will allow them to pay for the exorbitant health care costs which are currently commonplace in this country and at the same time leave a reasonable "safety net" of assets which would be available to provide for their dependents in the event of their demise. Most veterans with whom I have had contact express a great deal of concern in regard to the question "What will happen to my dependents if I have to spend all my available resources to provide for my medical care?"

It is my understanding that a figure of $15,000 in annual income has been arbitrarily chosen as the figure to determine whether or not a veteran would be entitled to Veterans Administration Health Care. From my understanding, it appears that if a veteran has an income of $14,999.00 per year that he would be eligible for inpatient medical care, yet if the same veteran's annual income exceeded the $15,000 figure, then he would not be eligible unless he "spent down" his income to the point that he could reestablish eligibility.

With the current costs of health care, a veteran who exceeded the $15,000 annual income rate could spend his entire annual income on an extremely short period of hospitalization, thereby leaving him and his family with no available income.

Question. 2. Do you find that veterans are often forced to enter nursing homes unnecessarily because their families cannot get the support services they need to care for them at home? What barriers do you run into and how might they be removed?

Answer. In the State of Florida, I deal with a substantial number of elderly veterans who, because of age and also because of their medical problems, have reached the point where they are no longer in a position to provide for their own care. Although the veteran may be in a position to feed and dress himself and to care for his basic personal needs, he may not be in a position to provide support services which he requires, such as shopping for food, cooking his meals, or cleaning his house. Because of his inability to carry on the support services which are necessary to his health and well being, the veteran commonly finds himself in a position where these services have to be provided for by family and/or friends and if this source of aid is not available to him, then the only recourse he has is to have himself placed in a nursing home environment where all services are being provided to him. It appears that a substantial amount of money could be saved by providing the veteran with the support services which are related to his health and well being, instead of placing the individual in a position where he has to enter a nursing home in order to obtain the services which are desperately needed in order to carry on his existence.

Another problem that has arisen recently, which does result in a veteran being unnecessarily placed in a nursing home, is when we are dealing with terminally ill or chronically ill veterans who are currently being cared for by spouses and/or relatives. In most situations, the individuals who are primarily responsible for the individual's care is required to give that care on a 24 hour per day seven day per week basis with no opportunity to take a day off or find time to be by themselves. In a lot of cases, families have attempted to provide the care for the terminal ill or the chronically disabled in the home environment, but because of the tremendous demand placed upon the individual who is providing the care, these arrangements very seldom last for any great length of time before the family realizes that they cannot continue to provide care to the individual on a continuous basis. These individuals are then placed in a nursing home so that they can receive the continuous care necessary. An alternative approach to this problem would be to devise a system by which the family member, who is providing the care, is given "time off" from the duties of providing continuous care to the individual. This could take place on a number of different fronts. One alternative would be to allow an individual who is in a continuous care environment to be placed into a hospital and/or nursing home on a temporary basis in order to allow the provider of services the opportunity to "take a break" from the daily grind of providing the care necessary. This would give the provider the opportunity to rest up from the rigors of continuous service to the individual and at the same time, would give the recipient of the care the opportunity to be evaluated in a clinical environment to determine if any additional medical treatment would be necessary for the individual.

In order to meet the needs of a veteran population which is rapidly aging, new concepts must be tried in order to find a substitute for the established policy of placing individuals in nursing homes and/or hospital environment and leaving them in these situations. The opportunity for the family to provide health care services to an individual is important, but to expect the family and/or friends to provide continuous round the clock care with no end in sight is totally unjustified.

CHAIRMAN ROYBAL TO MR. O'NEILL, VETERANS OF FOREIGN WARS

Question 1. What is the VFW's position on Congress' responsibility in protecting the 85% of all veterans who will never see a VA facility—many of whom are older veterans having to survive on low, fixed family incomes? Is medicare alone, with its out-of-pocket costs increasing, going to be enough?

Answer. It is the responsibility of the United States Congress to see that adequate funding is provided to meet the hospital and medical care needs of the veterans of this nation in accordance with the eligibility requirements.

The eligibility provisions currently established by law are adequate. The VA, through their regulatory process, is doing an excellent job in meeting the medical needs of the service connected cases.

However, in respect to the non-service connected veteran, the system does not have adequate beds. This is very evident by the fact that some 20,000 veterans, on a monthly basis, are denied admission to a VA facility—and with the aging veteran population—the denials will increase.

The VA's document entitled, "Caring for the Older Veteran" shows, under Strategies For The Future, answers as to how we can best meet the future medical needs of our veterans. VFW supports the VA's objectives as well as the time-table contained in the report.

In relationship to that part of your question about the older veterans having to survive on low, fixed family incomes and whether medicare alone with its out-of-pocket costs increasing will be enough, it is our feeling that the VA with the orderly plan that I just cited will be able to meet hospital, medical and nursing care needs of the older veteran.

We should add, the VA can deliver medical care 15 to 20% cheaper than the private sector. Therefore, common sense would tell us that, in the interest of the taxpayer, since 66% of american males over 65 years of age, by the year 2000, will have a potential eligibility for VA care, that we should expand the VA system to meet the demand. This would serve two purposes. It would relieve the veteran from out-of-pocket expenses and it would be a great saving to the medicare insurance program.

In this relationship, the U.S. Congress, some years ago in their wisdom, enacted into law the provision that non-service connected veterans over 65 years of age requiring hospital care do not have to establish the "inability to pay" feature—thus, encouraging him or her to use the VA medical care system instead of medicare.

Question 2. How are veteran service and aging organizations working together now at the local and national levels and what opportunities do you see for greater collaboration in the future?

Answer. At this point, I don't see any real strong program of veterans service organizations getting together with aging organizations.

I have been personally involved with community health organizations for many years and have been for some time and currently a member of the Greater Detroit Health Council and serving as a public Board member. I am also involved in the Detroit Area Agency on Aging for the past several years, but there are no other veterans organizations involved.

In respect to the future, I feel, on a local level (State), the veterans organizations could form some type of committee on aging problems, then each committee of each veterans organization throughout the state would form a council, then this body would form a Joint Committee with the private sector. As a matter of fact, I have been in contact with the Regional Medical Director, Albert Zamerlan, relative to developing such a plan—perhaps under the VA's direction.

In relationship to on a national level, I see no program being set up at this time.

CHAIRMAN ROYBAL TO DR. DALLERY, THE BRYN MAWR HOSPITAL, BRYN MAWR, PA

Question 1. Given the emotional tragedy families go through when they are forced to "spend-down" to medicaid, how will veterans react—men and women who have served our country in time of war—when they are asked to "spend-down" to the VA care they were promised?

Answer. The Spend-Down program is a process of phased impoverishment. It is not pleasant for anyone to have to go through it, and I hesitate to speak for everyone having to do so. However, my experience suggests that a veteran who has been counting on support from the VA will be shocked and angry to be told that it is now his/her duty to give up all assets and resources that might have been intended for other family members. A great many veterans continue to feel pride in their history of service to the country, and feel that becoming a "welfare case" is shameful. For many older people, the status of recipient of aid is extremely hard to accept, since it does not follow upon any effort of earning it. Care in the VA system is generally perceived to be earned by virtue of military service.

In short: A process that is odious and painful for everyone is most certainly going to be more so for the veteran.

Question 2. What kinds of informal or formal agreements between community providers like yourself and the VA would help you in getting veterans the care they are eligible for?

Answer. There are many ways services for veterans can be assured and improved through agreements between community providers and the Veterans Administration. Mr. Jon Hunter has testified very ably on this point before the Committee. I agree with all of his recommendations. The capability of contracting for services in the home and in the veteran's own community would be a vast improvement on the existing system. In my own community—Lower Merion Township, Pennsylvania—we have just organized a consortium for long-term care which enables participating agencies to provide consistent, coordinated, and effective care. The Veterans Administration is not a part of the consortium, and probably would not be unless legislation supported it.

In addition to contract for services, I believe there is a great need for joint training on the part of Veterans Administration social workers and community-based social workers.

In recent years, there have been technological and organizational innovations in the field of home-based care, and I believe the VA could very well begin to incorporate them one way or another. In my opinion, the best route to follow is contracting for services.

CHAIRMAN ROYBAL TO MR. JON HUNTER, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

Question 1. Given increasing numbers of veterans—85 percent of whom will never see the VA—added to pressures to scale down the VA system, will community providers be able to absorb greater demand for services? Will older veterans as well as non-veterans have access to the care they need?

Answer. Community service providers have been absorbing clientele in need of services from the growing general population; growing older veterans population; and acutely ill persons discharged from hospitals as a result of DRGs. Some absorption has been possible because Area Agencies on Aging have shifted target groups receiving service benefits under the Older Americans Act. However, there have been limited increases in Title 111B resources which support community in-home care and without increases in funding, future absorption of older veterans will not be possible. Limitation of resources and increased demand for services will force further targeting of services. Thus, access to community in-home services will be available for only the sickest and poorest of older persons.

Question 2. What specific types of sharing or contractural agreements do you think are possible between VA and community providers that would be beneficial to both?

Answer. There are examples of shared facilities and purchase of service agreements between some VAs and community service providers across the country. However, these examples, as cited in my testimony, are by no means a national picture. Since the VA is experiencing constraints in its own system, it may benefit the VA financially to contract for existing community services rather than incur the development costs of new services. The VA may be better able to serve certain older veterans in the community by purchasing a mix of in-home services rather than providing high cost acute care in the institutional setting. Community-based service providers currently support other institutional care providers such as hospitals, mental health centers, etc., by providing such services as transportation, adult day health, respite care for a pre-arranged reimbursement rate. This allows the hospital or mental health center to utilize their own resources to the maximum while supporting the community-based service provider.

One of the major hindrances in developing new services such as adult day health or respite care is often locating appropriate facilities. A contractual agreement could benefit both the VA and a community provider if the VA donates the space for the services to be provided in, in return for a commensurate amount of units of adult day health for VA clients.

Question 3. What has prevented these arrangements from being made in the past? Is it a question of knowledge, a need for more communication, a reluctance on the part of non-VA providers, or are regulatory and legislative changes needed?

Answer. It is my opinion that the major reason these arrangements are not prevalent is the hesitance of the VA to utilize service systems outside their own. Historically the Veteran's Hospitals have primarly been institutionally based and have been able to afford being self contained service systems.

In turn, the community has looked at the VA as primarily and institutional center and for many years, minimal knowledge about and coordination with each other systems has occurred. Ongoing education about each others changing systems will always be necessary. What needs to be changed does not seem to be statutory issues, but possibly regulatory. Many VAs state they are unable to use Veteran's Administration funds to purchase services outside their purview. It may be necessary to encourage in regulations the purchase of services outside VA entity when established community services exist and are less costly.

Question 4. To what extent have aging organizations worked with veteran service organizations in the past and what opportunities do you see in the future in this respect?

Answer. There are limited example that I am aware of where Veterans Service Organizations and Aging Organizations cooperatively work together. It certainly seems feasible, that together new program initiative could be shared with the other through joint training conferences, model program handbooks, and publications. The groups could work together to seek additional resources at the local, state and federal levels to meet the increasing needs of the growing veteran population. This relationship is definitely one to yet be developed fully.

CHAIRMAN ROYBAL TO MR. BARRY JACOBSEN, AMERICAN HEALTH CARE ASSOCIATION

Question 1. What are the most significant barriers that prevent or discourage community nursing home and other long term care providers for working more with the VA? How can they be eliminated? What, if any, legislation is needed to eliminate them?

Answer. Barrier: Small number of patients—Nursing homes in many parts of the country tell AHCA they are interested in expanding their involvement with the VA but the local VA hospital tells them they are not needed. The causes may be 1) long term care patients are in VA hospitals or 2) long term care patients in VA nursing home units.

Elimination—Prior to constructing a VA nursing home, local capacity for contract care should be thoroughly investigated.

Legislation—Probably not, but congressional oversight is extremely important.

Barrier: Service Contract Act—Nursing homes participating in the VA must meet certain wage and hour requirements put forward by the Department of Labor. This becomes either inflationary or impossible to comply with when applied to temporary and part-time employees. A growing number of nursing homes in certain parts of the country, fearing compliance visits by the Labor Department and ensuring fines, are dropping VA contracts.

Elimination—Nursing homes contracting with the VA should be exempted from complying with the Service Contract Act. AHCA believes that the Act is being inappropriately applied to modern nursing homes and that when enacted, it was intended to apply to purely service entities such as restaurants and hotels where the services provided are food and housing, rather than to health care.

Legislation—The Labor statute dealing with applicability of the Service Contract Act should be amended to exempt nursing homes.

Barrier: Reimbursement policies—Two VA reimbursement policies prohibit community nursing home placement of veterans with special needs. First, the VA reimbursement system calls for each VA medical center to negotiate a single rate with each nursing home. While this all-inclusive rate may be satisfactory for most VA referral patients, patients with extra needs such as more intensive nursing services, frequent physician visits, and laboratory studies, may exceed this rate to the degree that community nursing homes control afford to admit them. (Note: in cases where medicine and supply needs are exceptional, VA medical centers may provide these to the nursing homes to subsidize the cost.)

In the second instance, the VA is statutorily prohibited form paying any nursing home more than 45% of the cost of care rendered in VA medical centers. In most cases, the per diem paid by VA to community nursing homes does not approach this level. (Average cost in a VA medical center is $230 per day; 45% of this is $203.50; average community nursing home per diem is about $60.) The cost of nursing home care can exceed the 45% statutory limitation in the case of subacutely ill patients: medically stable ventilator dependent, total parenteral nutrition needs, head injured, other high need rehabilitation patients. While the nursing home care costs appear high, our experience has been that care of subacutely ill in nursing homes is approximately 30% of that care if provided in a community hospital.

Elimination—For the first problem, VA reimbursement policies should allow for nursing home reimbursement based on patient need for the group of patients who otherwise would be denied access to a community nursing home.

For the second problem, the 45% statutory limit on nursing home payment should be eliminated and the Veterans Administration should embark on a demonstration program contracting for the care of subacute patients in community nursing homes.

Legislation—The 45% statutory limit should be eliminated (Title 620(a)(ii) and Congress should direct the VA to embark on reimbursement demonstration projects for heavy care and subacute care patients.

Barrier—The scope of the VA community nursing home contact program is limited by the budget appropriated for the contract program. The Administration's FY 86 budget asks that the same amount be allocated, plus a small inflation factor. There is no room for growth in the contract program given the present budget figures.

Elimination—AHCA believes that the contract nursing home program budget should include a growth factor. We believe it is more cost effective for the VA to spend its limited dollars in contracting for services rather than building new facilities and providing nursing home services within the VA medical system.

Legislation—FY86 and subsequent budgets for long term care should include increases for the contract nursing home program.

Question 2. If the VA's community and state nursing home programs were expanded, what if any impact would this have on the non-veterans' access to nursing home beds, particularly those on Medicaid?

Answer. Access by non-VA patients would be dependent upon the number and growth of the number of nursing home beds in the geographic area. In some areas, there currently seems to be an overabundant supply of nursing home beds. In other areas, certification of need policies and nursing home bed moritoriums severely limit the number and growth of long term care beds.

Generally, nursing homes prefer to accept VA patients over Medicaid patients. The reasons are simple: VA pays bills on a timely basis and many Medicaid programs do not, a corps of VA consultants are available to follow-up the placement of the VA nursing home patient (this is not available for Medicaid patients), and finally, when medical problems arise, VA medical centers quickly arrange the transfer back to that medical center (such transfers may be difficult for Medicaid patients). For these reasons, in certain geographic areas where there is a limited number of nursing home beds, expanded use of the Va community contract program could limit access by Medicaid patients. Access by private pay patients would not be affected.

Question 3. Will nursing homes be able to absorb the caseload of heavy care patients that will be coming to them as a result of pressures on hospitals to discharge patients sooner and increasing numbers of veteran patients with special medical needs?

Answer. A growing number of nursing homes are developing subacute care units or are making provisions for heavy care patients. They are delivering high quality services in a cost efficient manner. As long as payment mechanisms (through Medicaid, Medicare, VA or private insurance) are available to permit utilization of additional resources (typically, manpower and equipment), nursing homes can provide care for heavy care patients being discharged early from hospitals and to care for veteran patients with special needs. However, in our view it would not be prudent for a nursing home to accept these heavy care patients without arranging additional resources because the quality and quantity of care permissible under most current reimbursement systems would be insufficient to meet these patients' needs.

Question 4. How much of a problem is the supply and distribution of nursing home beds? How much of it is a result of state and federal regulations under Medicare, Medicaid and the certificate of need process?

Answer. There are major shortages in the supply of available nursing home beds across the country. The shortage is not a universal one in that several states are overbedded, but shortages do exist on a state-by-state basis. The overall average occupancy rate of around 95% is one indication of the shortage, as well as back-ups in hospitals of patients awaiting nursing home placement. The shortage seems to impact heavy care and publicly funded patients the most.

Much of the shortage can be attributed to state and federal policies. Over a dozen states have banned construction of additional nursing home beds, some for a lengthy period of time. Sometimes, for these states the only thought is that an adequate bed supply will only increase state costs. For other states, there is the desire to develop a more rational long term care system. However, one way or the other, extended construction freezes lead to shortages. State use of certificate of need programs are used to satisfy the state's view of need, but budgetary capability may be a major part of the state's definition of need.

Beyond certificate of need regulations, states can restrict construction of nursing home beds more directly via their reimbursement systems. If Medicaid rates are set lower than what is required to provide adequate quality, or are strictly limited to support only a set number of beds, it is unlikely more beds will be built. This is a more risky approach than the certificate of need program because providers may complain loudly and quality of care may suffer. However, inadequate reimbrusement is a fact of life in many states.

Finally, through both state and federal regulation, failure to properly reimburse capital costs will continue to dampen interest in building additional nursing homes to meet the need of a growing elderly population. Many states have followed Sec. 2314 of the 1984 Deficit Reduction Act and frozen the value of capital. This action will greatly restrict the flow of capital into an industry which will need billions of dollars in new investment to meet the need for additional beds. A recent GAO study spoke of the long term care bed need not keeping up with the demand. Now at a time when demographics tell us the elderly population is growing even faster, these various impediments are likely to widen the gap between demand and supply.

Question 5. In our mind, do we have effective tools for measuring nursing home bed need and are these being built into state and federal planning processes?

Answer. Present methodologies for measuring nursing home bed need are not accurate. Most methodologies are based on existing utilization rates and/or synthetic estimates of population or system characteristics. As a result, critical planning elements such as the proportion of the target population that is in need of services but is currently not being served by the health care delivery system or the effects that development of home- and community-based services will have upon need for institutional services are, at best, educated guesses. Additionally, limited data is available and much data that is available is of questionable accuracy. Because of these and other limitations, long term care planning lends itself to the development of processes in which the planner(s) can jusify almost any desired planning objective.

CHAIRMAN ROYBAL TO DR. DONALD L. CUSTIS, PARALYZED VETERANS OF AMERICA, AND FORMER CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Question 1. In your opinion, is the VA doing enough to prepare for the long term care needs, particularly the non-institutional needs, of older veterans and to what extent does the answer lie in how the VA and non-VA sectors interact in the future?

Answer. In answering this question one has to distinguish between what the VA would like to do and what the Administration is permitting it to do. The Agency requested significant additional resources in the FY '86 budget to ready itself for the long term care needs of increased numbers of elderly veterans. Every request in this regard was denied by OMB. OMB will permit the expansion of non-institutional programs only if costs are absorbed in a decremental budget. The magnitude of the aged veteran impact is such that the VA alone, even under a more supportive Administration, cannot provide all care required. In my opinion, cooperative integrated community programs in which the VA could participate provide the most likely solution. They will, in fact, come to be an absolute requirement.

Question 2. Are you aware of any standing inter-agency committee or task force that could serve as a vehicle for VA/DHHS collaborative efforts at the federal level?

Answer. There is an interagency work group in the White House charged with health policy development. However, they have no operational authority and are thus far manifestly biased toward reducing federal involvement and subsidy for health care. Such a task force, I believe, would have to be created by Congress.

Question 3. What legislation is needed on both sides to encourage and permit sharing, contractual or other agreements between the VA and non-VA sector?

Answer. Legislation is needed to permit the VA to share any or all type resources with the private sector. Ideally seed money should be provided to encourage communities to create cooperative structures in which all federal and state programs could also be integrated.

Question 4. What more could the VA do to encourage the use of alternative long term care services that would obviate the veteran's need for hospital and nursing home care in the first place? What legislation is needed to expand the VA's authority in this respect?

Answer. Legislative authority is needed to permit the VA to place the nonservice-connected patient in a nursing home or into a non-institutional program without first being hospitalized. Furthermore, if adequate numbers of hospital based home care teams, adult day care centers, hospices, etc. are to be acquired by the VA, Congress is going to have to mandate them and not wait for a stifled VA initiative.

Question 5. What effect do you think the Administration's actions to scale down the VA system will have on the VA's geriatric education, residency and research programs that benefit professionals within and outside the VA system?

Answer. The VA is the nation's greatest health manpower production resource. It has been the forerunner also in geriatric education and research. The Administration's announced intent to "shrink the system slowly" will have a marked adverse effect on the nation's preparedness to meet the needs of the aged citizenry. This comes at a time when medical schools and private teaching hospitals are also experiencing further cuts in federal dollar support for medical education and research.

CHAIRMAN EDGAR TO DR. JOHN W. ROWE, HARVARD UNIVERSITY, DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION

Question 1. Are the elderly at greater risk of ill health and the need for chronic care than their younger counterparts and because they are dependent on fixed incomes, at greater risk of financial loss due to the cost of care?

Answer. As a group, the elderly are clearly at higher risk for ill health and chronic conditions. This is illustrated by a variety of measures. Self assessment of health is most positive in the younger age groups; less than 7 percent of those under the age of 35 assess themselves in fair or poor health as compared to 25 percent of those 55–64 and more than 30 percent of those over the age of 75 (National Center for Health Statistics, 1981 Health Interview Survey). Reports of specific physical conditions and disability increase with age as does the need for assistance in performing activities of daily living. For example, 5.2 percent of those 65-74 year old require assistance with one or more basic physical activities, 11.4 percent of those 75-84 require such assistance and 34.8 percent of those over the age of 85 need such assistance. Finally, elderly are at higher risk for use of all forms of health care. Acute hospital stays in the past year are reported by 11% of persons aged 45-54, by 16 percent of those aged 65–74, and by 20 percent of those over the age of 75. Average number of physician visits increases from 4.7 for those aged 45–54 to 6.3 for those 65 plus, and only 1 in 10 nursing homes patients is under the age of 65.

The cost of medical care are an increasing burden for elderly individuals. The percent of individual with out-of-pocket expenses for health services increases with age (69 percent of those 19–24, 83% of those 65 plus) as does the average amount of out-of-pocket expense and the percentage of income represented by out-of-pocket expenses (Walden and Wilensky, National Center for Health Services Research). Further, health expense have increased faster than the general rate of inflation, placing relatively greater demands on elders. In 1981, Medicare met only 45 percent of all health and long term care expenditures of the elderly (Davis, Health Care Financing Adminstration) with older persons on average spending $1,154 privately. In 1984 elderly had out of pocket health expenditures (15 percent) equal to pre-Medicare levels.

Question 2. To what extent is the non-VA community limited in how far it can go to augment the VA's capacity because of limits in the supply of nursing home beds, a lack of financing for alternative care services, and other limitations of non-VA programs for the elderly?

Answer. Care of the elderly is under a variety of pressures which limit the enthusiasm of VA and non-VA providers to develop new working relationships when such relationships may increase demand for already overtaxed services. These pressures include the changing demographics of the elder population resulting in increased numbers of elders seeking services, a continuing period of budget austerity exacerated by spiraling costs per unit of service, increased feelings of competition among service agencies, and changing demands on service providers which result from altered methods of reimbursement. Most states have made efforts to limit increases in numbers of nursing homes beds, but have been reluctant to make major commitments to the devlopment of alternative services. In many regions, community based agencies have long waiting lists for subsidized services. At the same time, acute hospitals, in response to D.R.G.s or other cost containment strategies, are discharging elderly patients earlier, in some cases making heavier demands on home health agencies and other providers of community based care. In this atmosphere, some non-VA providers have expressed reluctance to make commitments to further augment VA care, fearing that they will be swamped by service demands.

On the other hand, these very pressures may provide the impetus for cooperative activities among VA and non-VA providers. The recognition that both systems face similar problems may lead to an effort to identify complementary resources to be shared with mutual benefits. For example, legislative mandate limits the types of services provided by the VA. This means that older veterans who need certain types of comminity based long term services, turn, by necessity, to the non-VA service system. In like manner, the non-VA service systems in many areas report difficulty in accessing the sort of geriatric expertise that has been fostered in many VA Medical Centers. Carefully negotiated cooperative arrangements between the two systems could lead to improved care for elder clients, both veteran and non-veteran.

Question 3. Is there reluctance on the part of non-VA providers to work more with the VA? What are the barriers and how can they be eliminated?

Answer. The major barriers to better cooperation are lack of knowledge, confusion, misinformation, bureaucratic red-tape, and certain regulations and informal working rules. Lack of knowledge about the other service system is a problem for both VA and non-VA providers. The sorts of information needed include an understanding of the system as a whole, and of the many agencies an departments which provide services. The VA is a mystery for most non-VA providers. They are confused about eligibility requirements and priorities and how to gain access to VA services. Further, many non-VA providers do not know VA providers and therefore have no access point for information, referrals, or answers to questions. There is suspicion on both sides that patients are sometimes dumped from one system to the other. Efforts to develop cooperative arrangements often move slowly because of conflicting regulations and requirements. For example, VA providers are concerned about the acceptability of serving non-VA clients, while non-VA provider are concerned about giving veterans priority above other clients on the waiting list.

Overcoming these barriers requires action at the federal local levels. Certainly, sharing information about each system will be helpful in reducing confusion and encouraging better understanding. Meetings of VA and non-VA providers for the purpose of information sharing at the local level can begin to serve this purpose as well as introducing individuals to one another to facilitate future contracts. Directives and initiatives from the federal level will encourage local facilities to develop projects, as will support for the start-up costs of such efforts. The VA could also encourage cooperative arrangements by more flexible interpretation of eligibility priorities for veterans participating in joint programs, given that non-VA providers may find current priorities in conflict with their own eligibility requirements.

Just as the non-VA providers face barriers to working with the VA, the reverse is also true. A major barrier is the framented nature of the non-VA long term system. The number of agencies involved in long term care may in itself make collaboration a daunting proposition. In Massachusetts, for example, planning for extended care is distributed among the Departments of Elder Affairs, Public Health, Public Welfare, Mental Health and Social Services, the rate setting Commission, the Commission on Administration and Finance, and the system of local planning agencies. The complexity of the system may make more modest efforts, involving one or a few agencies more feasible in the initial stages.

CHAIRMAN EDGAR AND CHAIRMAN ROYBAL TO VETERANS' ADMINISTRATION

Question 1. To what extent are collaborative efforts already going on at the community level between VA and Non-VA providers that can serve as models in other areas of the country? Please cite examples.

Answer. At the medical centers, the VA works with community organizations on several levels: academic, administrative, professional/technical, and service delivery. The service delivery component, of particular interest here, is primarily intended to refer veterans to community health and social services following VA hospitalization. Service delivery components of VA/community relationships are primarily, though not exclusively, part of the discharge planning process to assure that veterans receive health care and social services to support their post-hospital adjustment and delay or eliminate the need for reinstitutionalization. This ongoing patient based referral function was reinforced and formalized in 1975 when the VA signed the Working Agreement for the Consortium on Information and Referral Services to Older People, as part of the Older Americans Act Comprehensive Amendments of 1973. This Agreement was updated and revised in April 1983. The Agreement provides that the VA will develop liaisons with State and local agencies to distribute information on benefits available to aging veterans and on these veterans' needs which the VA is unable to meet. In addition, the VA agreed to share technical information to assist those agencies in the planning, development, and operation of services to the aging. Finally, the VA will provide consultation and technical assistance to state and local agencies providing benefits and services to VA beneficiaries.

Section 106 of the recently enacted PL 98-528 reinforces the process of effective coordination in service delivery. Moreover, the Information and Referral Agreement seeks to raise the concept of VA/community interaction from a patient specific to a systematic level, coordinating VA benefits and services in the aggregate with State and local, public and private community agencies and sharing information about benefits and services with those agencies.

Our assessment of the situation is that at the patient level we have been largely successful in linking community based services with the needs of the patient. We estimate that virtually all VA medical centers have established contact with the Area Agencies on Aging and that, as a result, the level or appropriate referrals from the VA to community agencies, and vice-versa, has increased significantly.

In addition to extensive collaboration at the patient referral level, many VA medical centers offer to community agencies professional/technical assistance or other resources (short of providing direct services to non-veterans) in developing their community resources to serve the needs of the elderly. For example, VA medical centers in Illinois, Florida, and California have provided assistance to community agencies in setting up Life Line electronic monitoring devices to serve both veterans and non-veterans.

It is not possible to specify the extent of such endeavors because information on VA/non-VA collaborative projects is not routinely collected by VA Central Office at this time.

Except under certain, restrictive circumstances the VA legislative mandate does not permit the agency to provide direct services to non-veterans on a collaborative basis. One exception to this is the authority, provided in PL 98-160, to enter under contract into collaborative arrangements with community entities to provide adult day health care to veterans and non-veterans alike. An example of this kind of collaboration is at the VA Medical Center, Hines, Illinois, where the hospital has entered into a collaborative arrangement with the Proviso Township Council on Aging with support from private foundations, to form an Adult Day Health Care Center. The VA's contribution to this endeavor initially consisted of professional/technical assistance and guidance in forming the consortium and in obtaining grant funds. It now consists of 1.5 FTE direct care staff, who provide clinical services in the center to veterans and non-veterans alike.

Question 2. What actions have been taken by the VA during the past year to initiate cooperative efforts with DHHS—other than the Information and Referral Program? What has been the result of such actions?

Answer. Nationally, the Department of Medicine and Surgery is working with the Administration on Aging (AoA) to develop an agreement for jointly sponsored demonstration projects for VA/AoA collaboration. These projects would focus on (1) providing specific (in some cases newly developed) services to caregivers and patients with Alzheimer's disease; (2) developing new, community based treatment alternatives; (3) developing effective models of collaborative case management to produce optimal use of community resources; and (4) developing collaborative education programs for the clinical staffs of the VA system and the aging network. Further action on these initiatives awaits the naming of a new Commissioner on Aging.

The VA participated on the planning committee and on the program for the conference, "Issues and Strategies in Geriatric Education: 1985." This conference was sponsored by the Bureau of Health Professions of the Health Resources and Services Administration, an agency of the Public Health Service. The conference considered implications of new knowledge for curriculum development in the education of health professionals, its application in innovative clinical practice settings, and strategies and resources to implement desirable changes in educational programs.

The VA conducted an investigation survey of payments to contract nursing homes to determine whether there were duplicate payments made for some services by DHHS. The findings of that survey indicated that there are a modicum of duplicate payments. VA and DHHS staff recently met to plan for exchange of data tapes in order to monitor this problem on a national level.

The VA is also represented as an ex-officio member of the National Advisory Council on Aging which is the primary advisory body to the National Institute on Aging, NIH. There is additional involvement in the Inter-Agency Task Force on Research in Aging, and the Committee on Population Research and Statistics.

The VA has also been involved in the DHHS sponsored Task Force on Alzheimer's Disease and continues to be involved in the follow-up to those activities.

The VA has been collaborating with various other elements in DHHS on an ad hoc basis, such as the Task Force on Geriatrics and Gerontology Education and the various reviews of research and training grants.

Question 3. Is there a standing inter-agency committee or task force, other than the Committee on Information and Referral, in place now that could serve as a vehicle for better communication and colaboration between the VA and DHHS?

Answer. At present there is no single standing inter-agency committee or task force that serves as a vehicle for better communication between the VA and DHHS. Because of the enormous range of activities and responsibilities in DHHS relative to those in the VA, a single committee would probably not be very useful. There are numerous standing committees which deal with circumscribed areas of mutual interest and activities. The Interagency Committee on Research on Aging, co-chaired by NIA and VA staff, exchanges information and develops areas of interest in research on aging involving 31 Federal agencies. The Committee on Population Research sponsored by NICHD has had VA representation since 1970. The VA reviews proposals for (proposed) AoA Gerontological Long Term Care centers. The VA is represented on the DHHS Task Force on Alzheimer's Disease. VA staff are recipients and reviewers of research grants (on study groups and National Councils) for virtually all of the National Institutes of Health. Aside from those activities, the VA participates in numerous shorter term activities related to research, education, and patient care in aging, e.g., Life Safety Standards for Board and Care Homes, the Institute of Medicine Review of Nursing Home Regulations, etc.

Question 4. The Senate-White House budget agreement includes savings in fiscal year 1986 tied to the proposed means test. In light of the significant impact the means test will have on individual veterans and the fact that a White House study is being initiated on the means test, wouldn't it make more sense to delay any decision about a means test until the results are in?

Answer: In determining the eligibility of most nonservice-connected veterans who are under the age of 65, VA is required by law to ascertain whether those veterans have the means to obtain such care. VA has proposed enactment of legislation that would provide for a fair and equitable means test which will insure that only truly needy nonservice-connected veterans, who must certify their inability to defray, receive VA medical care. Additionally, as a matter of fairness, such legislation would require veterans 65 years of age and older to certify their inability to defray. Presently, these veterans are exempt by statute from such certification.

We have no knowledge of a White House study of the means test.

Question 5. Dr. Dallery told us how difficult it is to coordinate services between the private and VA systems. How then, under the proposed means test, will continuity of care be assured to the veteran who receives care outside the VA and then "spends down" to the point where he or she becomes eligible for free care from the VA? Are we talking about patients being transferred from hospital to hospital?

Answer: For the group of approximately 11 million veterans who have a statutory eligibility for VA medical care (service-connected veterans, former POWs, VA pensioners, etc.) and for those veterans who are the truly needy, the question of continuity of care is not a valid one since the VA could function as their primary source of care. Other veterans with higher incomes who would be found ineligible for VA care have the means to obtain continuing health care from the private sector. A very few patients whose care is transferred to the VA after they meet the "spend down" may have some problem with continuity of care.

The problems in continuity of care caused by the shifting of some veterans from private sector care to DM&S care will be minimized by exchange of patient care summaries and discussions between the discharge and receiving physician. These are standard procedures of health care regardless of the payor.

Question 6. Given the greater number of older veterans the VA will be serving and their greater long term care needs, wouldn't part of the VA's problem be solved by building in more incentives for the use of non-institutional care that would prevent veterans from having to use hospital or nursing home care? What is the VA doing in this regard and what, if any, legislative barriers exist?

Answer: The VA has several community care programs which can be utilized in lieu of nursing home care placement. The VA is increasing its Hospital Based Home Care (HBHC) Program capacity to include more VA medical centers, consistent with the agency's long range plans for the older veteran. HBHC is able to treat patients in the home and, thereby, delay or prevent nursing home placement. The VA's HBHC team includes the participation of the program physician who regularly makes home visits. The direct medical intervention by the HBHC physician enables the HBHC team to treat and manage a patient population with complex, interacting medical problems. Because of the high level of medical care which HBHC is able to provide, most patients are admitted to the program following a period of hospital care. The most frequently treated medical problems include malignant neoplasm, stroke, heart disease, chronic lung diseases, and adult onset diabetes mellitus.

The Community Residential Care (CRCP) Program has long served as a major alternative to hospitalization and nursing home care for veterans who do not require these levels of care but who require some personal care and supervision in order to remain in the community. Currently, approximately 12,800 veterans are provided care and supervision in our 3,400 homes throughout the country.

Originally designed as a program to provide community care for psychiatric patients, the target population now includes the medically infirm elderly veteran. One hundred and twenty-five VA medical centers operate a CRCP.

Legislation (Pub. L. 98-160) recently authorized the VA to operate and to contract for Adult Day Health Care (ADHC) as an alternative to nursing home care. Pursuant to this legislation, five new VA programs have been funded and are in the developmental process at this time. They should be fully operational by the 1st Quarter FY 1986. Four ADHC Programs which existed before the legislation continue to operate as well. Contracting for ADHC will begin as soon as funds are made available for this purpose. The VA's long range plans are to increase the number of ADHC Programs to 40 VA and 40 contract programs by 1990.

The VA's legislative mandate does not authorize the Agency to provide in-home support services such as homemaker, chore and transportation services. Thus, the Agency has relied on community agencies to provide such services.

Question 7. One problem cited earlier that may limit expansion of the VA's Community Nursing Home Program is the limited supply and unequal distribution of nursing home beds. Has this been the VA's experience as well?

Answer. Up to this time, the VA has not experienced any major difficulty in locating community nursing homes to care for veterans under contract since it has the flexibility (within the statutory limitation) to negotiate contract rates which reflect prevailing market rates. This has allowed the VA to suitably "penetrate" the community nursing home market as appropriated funds have become available. In addition, community nursing homes have frequently expressed satisfaction in working with the VA because the VA provides expert consultation on patient care, it pays its bills promptly, and it promptly readmits to the hospital those veterans whose needs can no longer be met by the nursing home. Nonetheless, the continuation of an essentially static nursing home capacity in the private sector of about 1.61 million beds will, in the not too distant future, become a problem for the whole nation as the population experiences increases of chronic illness and impairments with an aging population.

Question 8. Two areas of particular concern to my Committee are quality assurance under cost containment and the special needs of Alzheimer's victims and their families. What is the VA doing with the Department of Health and Human Services and independently to address these concerns?

Answer. While the VA currently is not involved with DHHS in any cooperative efforts in the area of quality assurance under cost containment, the VA independently addresses quality assurance through a number of programs and initiatives. Each VA Medical Facility conducts a Systematic Internal Review (SIR) program to assure that the quality of care and appropriateness of services provided to elderly veterans is satisfactory. Utilization review is a significant component of the SIR program. At the VACO level, a Systematic External Review Program assesses the effectiveness of those local quality assurance activities, as well as the quality of care delivered. The VA's Department of Medicine and Surgery is undertaking a project to establish a district-based peer review system which would ensure that the quality of care under the VA's resource allocation methodology will not be compromised because of cost containment considerations. This system parallels the DHHS PRO monitoring system administered by the Health Care Financing Administration to assure that quality of care is not compromised under Medicare's Prospective Payment System. All VA Medical Centers and Long Term Care Facilities are fully accredited by the Joint Commission on Accreditation of Hospitals.

VA activities with DHHS regarding Alzheimer's disease include:

1. Participation on the Secretary's Task Force on Alzheimer's disease.
2. Distribution of the Task Force Report to all DM&S field stations.
3. Collaboration with the Administration on Aging's long term care gerontology centers.
4. Selection for three of the initial five Alzheimer's disease centers of research excellence funded by the National Institute on Aging to be located in VA medical centers.
5. Participation in preparing the consensus document on clinical diagnosis of Alzheimer's disease, in collaboration with the National Institute of Neurological and Communicative Diseases and Stroke and the Alzheimer's Disease and Related Disorders Association

VA independent activities regarding Alzheimers disease include:

1. Providing care for veterans with Alzheimer's disease. The number of discharges with a primary diagnosis of dementia has increased by approximately 12 percent per year in the last four years (1981-1984).
2. Conducting research on the causes, diagnosis, and treatment of Alzheimer's disease. As of January 1985, there were 73 such research projects in active status.
3. Conducting research on clinical services for veterans with dementia, such as long term team follow-up for outpatients, and special wards for inpatients; research also on support services for family members and caregivers, such as education group support, and group therapy.
4. Focusing on Alzheimer's at five of the ten Geriatric Research, Education, and Clinical Centers (GRECCs).
5. Training more personnel in the special problems of dementia patients and their families, through the Geriatric Fellowship Program, postgraduate education programs, and interdisciplinary team training programs.
6. Providing special education on dementia for VA staff through: organizing visits by European dementia experts to VA stations; publishing the report of the European experts' recommendations to the VA: preparation of a Program Guide for all VA facilities; and participating in preparation for the forthcoming American Medical Association report on dementia.
7. Stimulating interest in and clinical services planning for the care of dementia patients through a centrally coordinated Medical District Initiated Program Planning (MEDIPP) project on dementia.

CHAIRMAN ROYBAL TO CAROLYNE K. DAVIS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Question 1. I was intrigued to learn that, as of this year, the VA will have a prospective system of resource allocation in place in the acute care, nursing home and ambulatory care settings. Is HCFA studying or working with the VA in light of your own research into nursing home prospective reimbursement? Will not the VA's experience help to shorten what you have estimated as a 2-3 year delay in recommending a nursing home prospective payment system?

Answer. HCFA is attempting to keep abreast of a number of prospective payment systems for skilled nursing facilities as they are implemented, including several State Medicaid systems and the VA system. We certainly hope to learn more about the VA's experience, since their system resembles one of the models we are investigating. Unfortunately, neither VA nor State experience will allow us to shorten our devleopment process significantly. The Medicare case mix differs substantially from that served by the VA or Medicaid. A case mix-based prospective payment system must be calibrated carefully for the relevant case mix or peculiar and unintended patterns of payment to providers will result. This implies that we cannot simply adopt a system designed for another population, but must proceed to develop our own.

Question 2. Has the possibility and cost of Medicare reimbursing the VA for services to eligible veterans been examined by HCFA? Would this be a cost-effective approach from the standpoint of government savings?

Answer. We have not investigated this possibility. Presuming that such a payment arrangement would have no major effect on the utilization of medical services by Medicare-eligible veterans, whether it would be cost-effective would depend primarily on whether the VA Medical facilities could provide care more cheaply than the rate Medicare would have to pay to private providers. If the total cost to the VA of treating an additional patient was greater than the price Medicare would pay for private treatment, then encouraging the patient to use VA facilities would increase total government costs.

Question 3. What types of cooperative efforts related to veteran's health care and research have taken place between HCFA and the VA during the past two years? Please cite examples of what types of cooperative activities are underway at the local and State levels.

Answer. HCFA and the VA cooperate on a number of activities. For example, HCFA's Office of Research and Demonstrations has provided the VA with data to use in estimating the end-stage renal disease volume potential for VA institutions. The VA has also used data from the HCFA prospective payment demonstration in New Jersey to incorporate a DRG component into the VA's hospital budgeting process. HCFA also provided information to the VA on the resource utilization groups (RUGs) approach to nursing home case-mix measurement. Finally, the VA has given us information to assist in several Medicare coverage studies mandated by Congress (orthopedic shoes, foot care, home respiratory therapy, and registered dietitians in home health).

Question 4. To your knowledge, are the added costs to Medicare of a VA means test reflected in the budget agreement with respect to HCFA for FY 86 or the out years?

Answer. We have no information on this point.

5. Question 5. Is any effort being made to re-examine the adequacy and distribution of current nursing home bed levels and how "need" for nursing home beds is assessed? Do we have effective tools for measuring nursing home bed need?

Answer. HCFA monitors the extent to which certilfied nursing homes and nursing home beds are available for its program beneficiaries. Following are the latest tables on the numbers of skilled nursing facilities and beds.

The responsibility for assesing the adequacy of bed levels and for developing tools for measuring needs are not located within HCFA but withing the Health Services and Resources Administration and the Office of the Assistant Secretary for Planning and Evaluation.

Development of need measurements is an on-going process in light of the changing nature of the health care delivery system. For example, there has been an increasing emphasis on providing certain services in the home (such as renal dialysis and intravenous therepy) that were previously provided in institutional settings.

MEDICARE SKILLED NURSING FACILITIES/TRENDS

	1970	1975	1980	1983	1984
Skilled nursing facilities	4,656	5,295	5,052	5,632	5,952
SNF beds (thousands)	334	287	436	512	530

Source: HCFA/BDMS, February 1985.

MEDICARE AND MEDICAID/SKILLED NURSING FACILITIES BY STATE

	Title 18 and 18/19 facilities	Beds	Title 19 only facilities	Beds
All areas	5,952	530,403	2,440	213,818
United States	5,947	530,228	2,440	213,818
Alabama	193	14,919	2	102
Alaska	4	36	5	385
Arizona	33	1,392		
Arkansas	11	389	98	10,689
California	978	90,833	176	13,918
Colorado	70	7,879	76	7,335
Connecticut	172	18,914	37	2,300
Delaware	19	1,219	1	22
District of Columbia	7	479		
Florida	274	31,053	85	8,172
Georgia	91	10,067	177	17,786
Hawaii	25	1,714	1	64
Idaho	56	3,684		
Illinois	261	12,909	185	20,594

MEDICARE AND MEDICAID/SKILLED NURSING FACILITIES BY STATE—Continued

	Title 18 and 18/19 facilities	Beds	Title 19 only facilities	Beds
Indiana	151	8,358	15	834
Iowa	23	584	2	47
Kansas	26	1,526	23	1,024
Kentucky	89	3,795		
Louisiana	12	2,017		
Maine	15	330	2	56
Maryland	112	11,446		
Massachusetts	113	6,199	230	13,160
Michigan	286	33,226	10	1,347
Minnesota	104	10,465	263	20,272
Mississippi	4	280	129	11,853
Missouri	120	12,637	47	4,084
Montana	63	4,246	17	1,177
Nebraska	18	1,631	14	1,090
Nevada	25	2,158		
New Hampshire	23	555		
New Jersey	142	19,562	86	9,310
New Mexico	11	327	1	20
New York	542	72,309	3	179
North Carolina	175	10,106		
North Dakota	58	5,338		
Ohio	409	37,844		
Oklahoma	8	255		
Oregon	55	1,733	3	115
Pennsylvania	487	40,795	102	6,532
Rhode Island	63	1,921	10	365
South Carolina	102	7,688		
South Dakota	7	676	59	4,505
Tennessee	74	3,825		
Texas	46	2,603	165	11,145
Utah	30	3,378		
Vermont	16	588	5	73
Virginia	65	2,166		
Washington	114	3,440	129	11,454
West Virginia	41	3,672		
Wisconsin	111	16,757	267	32,573
Wyoming	3	305	15	1,228
U.S. Territories and Possessions	5	175		

(1984 data)

Source: HCFA/BDMS.

Question 6. Two areas of particular concern to the Aging Committee are quality assurance under cost containment and the special needs of Alzheimer's victims and their families. What is HCFA doing with the VA and independently to address these common concerns?

Answer. HCFA administers the Peer Review Organization (PRO) program whose primary goal is to assure the quality of care provided to Medicare patients. Our contracts with PROs contain specific, quantified objectives for reducing medically unnecessary or inappropriate admissions and improving the quality of care. Under the prospective payment system, PROs perform certain review functions designed to assure the continuing quality of care. For example, PROs review hospital readmissions to assure that premature discharges are not occurring.

The Medicare program was not designed to target program coverage to patients with specific diagnoses or conditions, with the exception of end-stage renal disease and hospice care for the terminally ill. Patients with Alzheimer's disease are eligible for the services currently covered by Medicare, including physicians' services and care provided in hospitals, skilled nursing facilities and in the patients' homes, among others. Under the Medicaid program, States provide physicians services, and care in both skilled and intermediate care facilities as well as in the home. States also have the option to provide other services such as adult day care and personal care services to assist individuals in the activities of daily living, which might be very helpful to Alzheimer patients. States may also operate programs of home and community-based services as alternatives to institutional care which provide services such as adult day care and respite care.

At the present time, HCFA and the VA are not jointly working on projects concerning quality of care or Alzheimers disease.

Chairman Roybal to Mr. Fraser Fisk, Agency on Aging

AOA–VA NATIONAL COOPERATIVE EFFORTS

Question 1. What actions have been taken by AoA during the past year to initiate cooperative efforts with the VA at the national level—other than the information and referral program? What has been the result of such actions and what future plans are in place in this respect?

Answer: During the past year, AoA and the VA have joined with the National Institute on Aging, the National Aeronautics and Space Administration, and the National Institute of Handicapped Research to apply NASA aerospace technology to the product needs of older persons.

In addition, AoA is encouraging State and Area Agencies on Aging to work with VA counterparts at the community level. A number of the AoA-supported Long Term Care Gerontology Centers (LTCGC's) are already working with VA components to improve services to older persons. For example, the Suncoast LTCGC completed a research project in which a survey instrument for determining the "functional status" of older persons was developed and then applied in determining functional status differences among elderly VA patients in four distinct long-term care settings. The Suncoast Center is also providing technical assistance in the establishment of a Geriatric Dentistry Program to benefit older veterans. The UCLA/USC LTCGC has assisted in the development of a geriatric assessment instrument to be used in determining the health status of older veterans and has also designed a number of training programs for VA staff.

In addition to the LTCGC activities, representatives of AoA and other network agencies took part in the conference on "VA/Community Resources and the Older Veteran" held at Harvard University in 1983. Participation in this conference provided additional insights about both the opportunities and the benefits of close coordination.

AoA and the VA are continuing to explore possibilities for national-level initiatives. At the same time, AoA continues to encourage State and Area Agencies to initiate contacts with their VA counterparts.

FEDERAL INTERAGENCY COMMITTEES

Question 2. Is there a standing inter-agency committee or task force, other than the Committee on Information and Referral, in place now that could serve as a vehicle for better communication and collaboration between AoA and the VA at the national level?

Answer: AoA and VA have joined with the National Institute on Aging, the National Aeronautics and Space Administration, and the National Institute of Handicapped Research around a specific undertaking—applying NASA aerospace technology to product needs of older persons. AoA and the VA are members of the HHS Alzheimers' Disease Task Force, another group focused on a single problem. There is, however, no broadly-composed permanent coordinative group, other than the Consortium for Information and Referral which now also includes representation from the private sector.

COMMUNITY SHARING BETWEEN VA AND NON-VA PROVIDERS

Question 3. What specific types of sharing or contractual agreements between VA and non-VA providers in the community would be beneficial to elderly veterans and non-veteran alike? What, if any, legislative changes are needed to permit or encourage such agreements?

Answer. AoA is currently working with the State and Area Agencies to insure that they will be able to respond properly to the needs of all the older persons, including older veterans.

To address these needs, State and Area Agencies will have to increase their current capacities in several ways. Due to the increase in absolute numbers of older people, AoA anticipates that an expansion in the capacity to increase currently available types of services will be necessary. This will entail more effective use of existing resources; partnerships and linkage among public voluntary and for-profit organizations; and more cost-conscious approaches to service delivery. Because the needs of the older population are changing at the same time that the elderly are increasing in numbers, we will have to be sensitive to the need for a variety of new services, especially innovative forms of home and family care. We will need to identify ways to assist families with older veterans to help themselves and avoid institutionalization. Older veterans will benefit from an improved array of home and family oriented services as will other segments of the older population. The Administration on Aging has been working closely with the Veterans Administration to develop the capacity of both networks to meet future needs.

Some example of successful interactions between the VA and local agencies include VA-developed computerized invenstories of community resources to which veterans can be referred, a community-based Adult Day Health Care program using a veterans service organization's meeting hall, and rental of veterans hall facilities for congregate meal sites.

Area Agencies on Aging and local institutions of the Veterans Administration as well as local veterans, membership groups have shared, and continue to share, facilities and resources, infomation, clients, learning, and advice. This friendly cooperation between networks has not grown from federal mandate, but is born of necessity and recognition of common concerns and missions.

The VA natinal network of health facilities and programs, administered locally through 172 VA Medical Centers, needs to work closely with the network of State and Area Agencies to implement a new conception of long term care for impaired elderly veterans—a complete continuum of community-based long term care services so that old people can continue to live in their own homes with a sense of dignity and personal identity.

No legislative changes are seen as necessary at this time.

HON. JOHN PAUL HAMMERSCHMIDT TO VETERANS' ADMINISTRATION

Question 1. A witness during the hearing on April 23, 1985, stated that VA facilities are screening patients for "rehabilitation potential." Please tell the Committee if this occurs, and if patients without such potential are denied admission. Also, if this kind of screening is taking place, please cite the regulation, policy or law upon which it is based.

Answer: The VA Nursing Home Care Unit mission is to: (a) provide compassionate, skillful care to those patients needing long term rehabilitation in order to restore them to their optimum level of functioning, and (b) provide care that will prevent or delay deterioration of those patients having profound physical disabilities and/or behavior management deficiencies. Delivery of care typically occurs over an extended period of time and is directed toward those patients who demonstrate a relatively less rapid potential for improvement, or toward patients whose rehabilitation goal is the maintenance of existing functions.

Admission to VA Nursing Home Care Units is based, first, on the medically determined need for skilled nursing services and, second, on the veteran's eligibility, based on veteran status, to receive such services (the same as for other bed services in the VA). A screening committee of professonals determines medical need for skilled nursing care which refers to the provision of skilled nursing services in a setting that utilizes an interdisciplinary team approach to care, as well as the resources of a hospital based nursing home. It is not VA's policy to exclude admission of veterans solely because they lack rehabilitation potential. Admission to a specific VA nursing home depends on current availability of resources and the mission of the hospital.

Question 2. Please expand upon your testimony that discussions and joint planning have been initiated with the Health Care Financing Administration.

Answer. The Assistant Chief Medical Director for Geriatrics and Extended Care has participated as an ad hoc member of a long-term policy group of the Health Care Financing Administration. His role, in these informal meetings has been that of a consultant to advise HCFA of some of the possible ripple effects of proposed actions they were contemplating.

Question 3. Does your testimony on page 4 of your statement mean that for Fiscal Year 1987 you plan to submit specific budget requests to implement at least a portion of your aging report of last year?

Answer. The Agency's FY 1987-1991 Plan/Budget request is currently under development. Initiatives which address the objectives in the report "Caring for the Older Veteran" are being considered.

Question 4. What kind of special training do you sponsor in the field of geriatrics?

Answer. Special training in geriatrics is provided in the following programs:

1. Physician Fellowship Program in Geriatrics. These two-year programs offer specialized training in geriatrics/gerontology for physicians who have completed residency training in certain acute care specialties.
2. Dentist Geriatric Fellowship Program. Two years of study in geriatrics is offered to eligible dentists who have completed their specialty training.
3. Geriatric Resident Positions. Special one year position allocations are awarded for rotation of residents into geriatric settings.
4. Interdisciplinary Team Training in Geriatrics. Training for students from various disciplines in the team approach to care is given in conjunction with ongoing geriatrics programs.
5. Clinical Nurse Specialists. Master's level students in nursing receive specialty clinical training in geriatrics/gerontology as part of their formal educational program.
6. Gerontological Nurse Fellowship. Doctoral nurse candidates complete their research in an area of gerontological nursing.
7. Associated Health Trainee Positions. Trainee positions focusing on clinical training in geriatrics/gerontology are funded for affiliating students in a number of health disciplines.
8. Continuing Education in Geriatrics/Gerontology. Continuing education activities in geriatrics/gerontology is provided for professional staff through the Regional Medical Education Centers; Cooperative Health Manpower Education Programs; Dental Education Centers; Continuing Education Center; Geriatric Research, Education and Clinical Centers (GRECCs); and the Engineering Training Center.

Question 5. Do VA nursing beds necessarily have to be adjacent to VA hospitals?

Answer. VA nursing homes are built on the campuses of VA medical centers or they are part of existing hospital buildings which have been modified for use as a nursing home bed unit. Accordingly, "adjacent" is a relative term and can mean a section of a hospital or new construction somewhere else on the campus of a VA medical center. Proximity of a new NHCU to the hospital is one of several factors used in selection of the actual construction site. Building on the VA medical center campus saves the VA the cost of new land and provides efficiency in provision of professional support services as well as food, laundry, security, and other necessary support services. An internal VA study completed in 1983 on the topic of locating nursing homes remote from a VA medical center identified the services that would have to be duplicated if the NHCU was constructed as a free-standing nursing home some distance from a VA hospital, and verified that such a facility would be more costly to operate.

The VA position is that a decision to operate a VA NHCU off the medical center campus must be made on a case by case basis. If grassroots planning procedures identify a clear demographic need for a nursing home away from an existing VA medical center campus, then the feasibility of creating such a facility will be considered. At present, our practice of using existing VA medical center campuses for nursing home sites has been satisfactory.

Question 6. Do you need any legislative authority for more outpatient activity in the geriatric field, particularly in the area of preventive or early treatment?

Answer. Recognizing the efficacy of preventive or early treatment of diseases and disabilities in order to ensure the best possible health care of veterans, we believe there is adequate legislative authority to provide such care. The VA may furnish medical services for any disability on an outpatient or ambulatory basis where such services are reasonably necessary in preparation for, or to obviate the need of, hospital admission [38 U.S.C. § 612(f)]. In addition, specific authority for a preventive health care services pilot program has been provided by Public Law 96-22, as amended [38 U.S.C. § 661, et seq.].

Question 7. A witness has testified that paperwork to transfer a patient from a community hospital to a VA hospital is extensive and typically takes days or weeks. Will you please comment?

Answer. If the VA receives a request for an eligible veteran to be transferred to a VA facility, and the veteran is in need of acute care, such transfers usually can be accomplished with little delay provided necessary beds are available. If the veteran is in need of nursing home care or long-term (intermediate) medical care, then additional information may be requested from the community hospital to assess the patient's needs. Many VA facilities run waiting lists for these services and it may be weeks before a bed is available for transfer from the community hospital.

Question 8. Do you often find a great deal of pressure to transfer patients from a private facility after private medical insurance has run its course or after Medicare has been exhausted?

Answer. In many instances when a private facility is anxious to transfer patients to the VA, the patient is no longer in need of acute hospital care and nursing home, rehabilitation or other long-term care is indicated. Veterans' families, service organizations, and other individuals often express considerable interest in the transfer of a patient into a VA facility for care.

Question 9. Please estimate the number of VA patients on any given day who are really nursing care cases and could possibly be out placed if facilities and conditions permitted?

Answer. In 1983, there were approximately 7,700 patients being treated in VA hospital bed sections who could have been treated in nursing homes if facilities and conditions permitted. Results from a new survey concerned with this subject should be available in October 1985.

Question 10. What resistance, if any, do you encounter because of your payment rates for contract nursing care?

Answer. The VA is not experiencing any difficulty or resistance on the part of nursing homes to participate in the Community Nursing Home Program because of our payment structure. No difficulties are anticipated in this regard in the future because the statutory limitation [38 U.S.C. § 620(a)(2)(ii)] on cost of providing community nursing home care has not been nor is expected to be restrictive.

Question 11. Please compare your per diem rates in VA nursing homes with those in private nursing homes.

Answer. The average per diem costs nationwide to the VA for 1984 for providing veteran nursing home care were:

VA Nursing Home Care Units (VA NHCUs)	$107.84
Community Nursing Home Care (CNHC) facilities:	
Average per diem paid	55.19
VA support	3.19
Total	58.38

Historically, the average per diem cost nationwide of operating a VA NHC Unit has been higher than contracting for CNHC. One of the reasons is that the costs used to compute the average per diems have different bases. The VA nursing home care total cost is the summation of personnel and other costs incurred at those VA medical centers with nursing home care units. These costs have been distributed from organizational cost centers (i.e., medicine, radiology, etc.) to bed sections (i.e., medical, surgical, nursing home, etc.) based on estimates of usage of personnel time and other services rather than on the basis of individual patient charges for services received. The collocation of the VA nursing home with a hospital and the methodology for distributing all medical center costs may inflate the cost of VA nursing home care. Conversely, the community nursing home care cost is the summation of payments for care based upon negotiated rates for basic nursing home care services. These rates are operationally controlled so as not to exceed the legislative limitation that the rate not exceed 45 percent of the cost of care furnished in a VA hospital. Because of these limitations the average per diem cost to the VA is most likely less than the national average per diem cost for all community nursing home facilities, and is slightly higher than Medicaid rates. As would be expected, the per diem costs of specific VA nursing home care units and community nursing home care facilities under contract with the VA vary widely from the nationwide average costs.

Another reason for the differences in per diem cost is that the services provided in VA facilities are not the same as those for which the VA contracts with community facilities to provide to a potential veteran placement. VA facilities provide a full range of services, without exclusion, to meet the varying needs of all veterans for nursing home care. Many patients need, and receive, much more intensive patient care services than the typical nursing home care patient. For instance, they require and receive specialized therapies and other services available at a medical center. On the other hand, VA contracts for basic nursing care services from community facilities for a negotiated rate. Community facilities generally will not provide a full range of services, such as occupational and physical therapy or expensive medications, to meet the needs of all veterans for nursing home care at a rate the VA is disposed to pay. Therefore, community nursing homes will not accept all patients that the VA proposes for placement at the contract rate, and usually exclude those requiring more than moderate patient care services. If more than routine services are required by a particular patient, such services are paid for separately or provided directly by the VA. The costs of such services are reflected in the community nursing home care per diem as part of VA support cost.

A third reason for the difference is that VA Nursing Home Care Units have a higher staffing cost than community nursing home care facilities. Cost of nursing services in VA Nursing Home Care Units is greater than the cost of nursing services in community nursing home facilities due to a greater number of nursing care hours provided per patient per day and a higher proportion of licensed nursing personnel to nursing aides. Also adding to the higher staffing cost in the VA Nursing Home Care Units is the greater utilization of appropriately trained clinical dietitians, dietetic technicians, and food service workers.

The VA does not require community nursing homes under contract to provide a breakout of costs during rate negotiation. Because of this and the above reasons, there is no common basis for comparing the cost of VA nursing home care and community nursing home care contracted for by the VA.

Question 12. Please compare construction costs of VA nursing beds with those of the private sector.

Answer. We have been unable to make an accurate comparison of Veterans Administration nursing home construction costs with the private sector that takes into consideration all the differences between what we build and what is built in the private sector. GAO was also unable to do so except for some state grant nursing homes. Also, it was not known what private sector costs were used to support the Grace Commission report about Veterans Administration nursing home construction costs. Harvard Professor Steven Kelman, in the winter 1985 issue of "The Public Interest," points out some of the differences of Veterans Administration nursing home construction. Some of these differences and others are elaborated upon in the following paragraphs.

Veterans Administration nursing homes are established at fixed VA medical center locations to serve veterans from much larger geographical areas than the individual communities in which they are located. They are used for veterans who have little or no potential for community outplacement and who otherwise would remain in acute hospital beds longer than necessary. They are, in a sense, facilities of last resort for veterans whose need for care cannot be provided elsewhere.

Construction standards established by law for VA nursing homes frequently are more stringent than those with which non-government facilities must comply. For example, private proprietary nursing homes may be of combustible construction. VA nursing homes are required to be of noncombustible construction. Moreover, as a matter of policy for patient protection, stimulated in part by the number of fatalities in recent nursing home fires, each new VA nursing home is equipped with a complete system of automatic sprinkler protection.

Consistent with its unique mission regarding treatment and rehabilitation of physically handicapped veterans, the VA requires all of its new facilities to be barrier-free throughout. Proprietary facilities generally do not conform to the same stringent standards.

The community nursing home exercise their own control of contract veteran admission. They can decline such an admission if they feel they do not have the proper facilities and staff to provide the full level of care required by the veteran. Hence the types of patients in VA nursing homes generally require more intensive medical and nursing care than do patients in private facilities. Provision of these additional services in the VA nursing homes often allows the patient to remain in the nursing home instead of being admitted to the acute hospital for treatment. Patients in proprietary nursing homes generally are transferred to a hospital whey they require similar services.

Question 13. Please compare a typical VA nursing patient with one under contract in a private nursing facility.

Answer. The VA Nursing Home and Community Nursing Home patient population can be compared on a number of characteristics. All data are drawn from the One Day Census in 1983. At the time of the Census, there were 8,943 patients in VA Nursing Homes (VANH) and 10,460 patients in Community Nursing Homes (CNH).

Age: The average age of patients in VANHs was 70 years compared to 68 years in CNHs in 1983. In VANHs, 64 percent of the patients were 65 years or older; 58 percent of the CNH population was age 65 or older. VA Nursing Homes also had a higher proportion of the "old-old", those 85 years and older. That group represented 21 percent of the VANH census compared to 15 percent in CNHs.

Sex: Both populations were overwhelmingly male. In VANHs 96 percent of the patients were men; in CNHs, 98 percent were men.

C & P Status: The populations were also similar in their Compensation and Pension Status. In VA Nursing Homes, 37 percent of the patients were service connected and receiving compensation; 34 percent were non-service connected veterans receiving pensions; and 29 percent were non-service connected and not receiving pensions. In the Community Nursing Home Program 45 percent of the veterans were service connected and receiving compensation; those in receipt of non-service connected pension represented 26 percent of the population; and 29 percent of the CNH patients were non-service connected and not receiving pensions.

Primary Diagnosis: In the 1983 Census, the majority of VA Nursing Home patients, 63 percent, had a general medical or neurological primary diagnosis. In CNHs, a general medical or neurological diagnosis accounted for 61 percent of the patients. Patients with primary psychiatric diagnoses represented 37 percent of the VANH population and 39 percent of the CNH population.

Level of Disability: Data are not available to compare the levels of disability of the two populations, as this information is not centrally collected on Community Nursing Home patients.

Question 14. Please compare your staffing and pay levels in a VA nursing home with staffing and pay in a private facility.

Answer. The data are inadequate to compare staffing and pay levels in VA and private nursing homes, as existing information on private homes is eight years old. It may be possible to make such a comparison following the publication of the 1986 National Nursing Home Survey to be conducted by the National Center of Health Statistics.

Experience indicates a number of differences between the staffing and pay levels of VA and private nursing homes. VA Nursing Homes tend to be better staffed at a higher pay scale than private facilities and use a higher proportion of registered nurses to nursing aides. VA Nursing Homes also use more full-time enployees and do not use nurses on contract to provide patient care. It is generally believed that VA facilities experience less staff turnover than private homes. The VA also provides such services as dietary and pharmacy consultations, as well as physical, occupational and speech therapies through full-time, in-house staff rather than contracting for these services with private providers.

Question 15. What would be the effect on the VA medical system if some veterans over age 65 had to use Medicare before being eligible for VA care?

Answer. Since most veterans with dual entitlement to Medicare and to VA care already choose to use their Medicare benefits in private facilities, requiring some veterans over age 65 to use Medicare before being eligible for VA care would have little effect on the VA medical system.

Question 16. What is the turnover rate in a typical VA nursing home? Please compare with the private sector.

Answer. In fiscal year 1984, the average monthly turnover rate was 7 percent in VA Nursing Homes and 19 percent in the Community Nursing Home Program. There is no comparable data for the private sector at large.

There is some data, however, on length of stay which can be compared. The 1977 National Nursing Home Survey conducted by the National Center for Health Statistics found that 64 percent of the patients in private nursing homes had a length of stay in excess of one year. The mean length of stay was 2.6 years with a median length of stay of 1.6 years. In 1983 the VA survey of nursing home patients in VA units found that 62 percent of the patients had a length of stay in excess of one year. The mean length of stay in VA Nursing Homes was 2.9 years and the median length of stay was the same as the private sector, 1.6 years.

Question 17. Do you have figures on the number of female veterans in VA nursing homes or under cotnract to VA in private nursing homes?

Answer. In the 1983 One Day Census, 185 or 2.5 percent of the patients in VA Nursing Homes were female and 334 of 3.7 percent of the patients in the Community Nursing Home Program were female.

Question 18. How do you see the future of the domiciliary program? This question is asked because the patient load in doms is substantially lower than it was some years ago.

Answer. The Domiciliary Program is by nature dynamic, constantly striving to keep pace with the changing needs of a changing veteran population. Many of the country's 16 VA domiciliaries, containing approximately 8,000 beds, will have been renovated or replaced by the mid-1990s. The many therapeutic programs that comprise domiciliary care are currently being reviewed in order that the VA may assure their relevance and effectiveness.

The VA Domiciliary Program provides an important level of care for selected veterans no longer requiring hospital or nursing home care but who are not ready for discharge to the community. The mission of the domiciliary is to provide, in a therapeutic and home like environment, ambulatory medical care and support services to a veteran population which will require care for varying periods of time. While the primary objective of the program is to restore the patient to independent or semi-independent community life, the overriding goal is to assure that each patient may attain and be maintained at his or her optimal level of functional independence and health. It is expected that most patients will return to community life after a relatively brief period of care in the domiciliary. Some, however, including a nucleus of current patients, will require this level of care for an indefinite period of time.

As the domiciliary continues to evolve in response to the demands placed upon it, it will doubtless remain a viable alternative for the veteran who no longer requires the acute care that a hospital offers, and does not need the services most commonly associated with nursing home care. It will remain a halfway step between acute care and the community. It will continue to offer a semi-protected, semi-structured therapeutic environment while at the same time providing optimal opportunity for community interaction both inside and outside the institution. The veteran patient will continue to be offered appropriately graduated independence necessitating self reliance not possible in the hospital or nursing home. While obviously not suited to the needs of all patients, for many the domiciliary offers a clear opportunity to reach for, and hopefully attain, their maximum potential.

The gradual reduction in the patient load of the VA Domiciliary Program during recent years is a direct result of major improvements in admission screening processes and in discharge planning practices. Consistent with legislative intent, the leadership of the Domiciliary Program has successfully initiated measures designed to assure the provision of appropriate care to only those veterans who demonstrate a clinical need for care and are entitled or eligible to receive such care.

It is anticipated that increased awareness of the mission and resources of the domiciliary in the public and private sectors of the health care industry will result in a reversal of recent declines in program workload.

Question 19. Do you foresee a possibility of VA contracting for and administering entire sections of private nursing homes?

Answer. Current legislative authority allows the VA to contract for skilled and intermediate nursing care of veterans in private nursing homes. This authority has been sufficient to meet our needs for contract nursing home care since 1965 and we see no reason for change at the present or in the foreseeable future. Contracting for an entire section of beds in a private nursing home would reduce our flexibility to contract for beds on an "as needed" basis and in the worst case it could make us responsible for paying for beds that we might not be able to use or desire to use for particular patients who need care in a contract nursing home.

Assuming that ". . . administering entire sections of private nursing homes" means using VA professional and support staff to provide care to eligible veterans in a section of a private nursing home, the VA has, as a result of a 1983 study, determined that it would be more expensive for us to operate in such an environment because of costs of bringing staff, supplies, and other resources to the private nursing home. The VA position is that if our grassroots planning procedures identify a need for developing such plans then we will do so on a case by case basis.

Question 20. Do you foresee a time when the usual six-month limitation on VA nursing bed contracts will be eliminated or expanded?

Answer. The VA does not see a need to change the maximum six-month limitation for nonservice-connected veterans in the Community Nursing Home Care Program. The maximum six-month period provides a sufficient period of time for the veteran and his or her family to make arrangements for alternative financing of nursing care in almost all cases.

Question 21. Have you noted any increase in applications for VA care as a result of Medicare cutbacks?

Answer. Although we have seen a small increase in the number of applications in the past fiscal year, it is impossible to ascribe this change to any one cause.

Question 22. Give us a breakdown of the 20,000 veterans who are turned away from the VA each month. For instance:

a. How many need inpatient care?
b. How many need outpatient care?
c. How many are over age 65?
d. How many are admitted or cared for by other health care facilities?
e. How many do not need care?
f. How many are not eligible for VA care?
g. How many come back to VA for later admission?

Answer. The estimate of 20,000 veterans being turned away per month is an extrapolation from the data produced in a VA-conducted survey. It is based on three components: (1) applications in admitting (65% of total); (2) telephone requests for transfer from non-VA facility to VA (10%); and (3) discharges from clinics (25%).

Everyone counted as "turned-away" was either in, or judged eligible for VA care and in further need of medical care that the VA was unable to provide. The survey was designed to provide an estimate of demand for VA medical care. To minimize response burden, information on the type of care needed, the demographics of turnaways, and what happended to turnaways was not collected in this initial effort.